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ABSTRACT

Presented is the guide to the Illinois project entitled "An Inter-Disciplinary Approach to Early Education of Handicapped Children Ages 0 - 3 Years" which includes information on funding and public awareness, diagnosis and evaluation, child development-home program, speech and language, structuring the day program, job descriptions and training, and parent involvement. It is explained that physically handicapped, developmentally delayed or retarded, speech and hearing impaired, behaviorally or emotionally disturbed, and multiply handicapped children are provided complete evaluation services and the following program options: 0-3 homebound program, public school early education programs, nursery schools, other agency day programs, allied agency's developmental training program, out patient occupational therapy, and out patient physical therapy. Reported are statistics showing rises in mean percentage of functioning (functional level divided by chronological age) between first and last testing for program participants. Provided are charts, forms, outlines, and diagrams for such program components as personnel, developmental evaluation, hearing tests, observational guidelines, behavioral objectives, developmental tasks, vocabulary lists, language evaluation tools, language definitions, guidelines for class organization and management, job descriptions, summaries of inservice training experiences, and outlines for parent groups. (DB)

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REPLICATION OF AN INTER-DISCIPLINARY APPROACH TO EARLY EDUCATION OF HANDICAPPED CHILDREN AGES 0-3 YEARS

AWARDED BY:
BUREAU OF EDUCATION FOR THE HANDICAPPED
U.S. OFFICE OF EDUCATION
UNDER THE PROVISION OF PUBLIC LAW 91-230

TO:
PEORIA ASSOCIATION FOR RETARDED CITIZENS
UNITED CEREBRAL PALSY OF NORTHWESTERN ILLINOIS

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Dr. Harold Phelps, Advisory Board Chairman
Mrs. Barbara Smiley, former Project Co-director
Project Advisory Board

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To all the children who through their similarities and differences have given us a clearer insight into aiding the very young handicapped child...

Children are like flowers,
They are fragile, different, and beautiful,
And it is their difference that makes them beautiful.

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INTRODUCTION

The birth to three experimental project "An Inter-Disciplinary Approach to Early Education of Handicapped Children Ages 0-3 Years" was co-sponsored by the United Cerebral Palsy of Northwestern Illinois and Peoria Association for Retarded Citizens. This model project was one of the initial programs in the United States and the first in Illinois designed to provide comprehensive services for the handicapped child from birth to three years in hopes of intervening at the earliest point in a child's life to facilitate a maximum degree of self sufficiency and independence. Funding for the three year experimental phase and continued funding for Replication of the original project has been provided by the Bureau of Education for the Handicapped under Public Law 91-230. Direct service to handicapped children has continued since termination of federal funding through state and local resources.

The worth of such a program has been and continues to be demonstrated through the observable developmental gains of young handicapped children in individual areas of delay. The mean gains in each skill area of the children participating in the project over the three year period have been depicted in Figure I. Every child was tested a minimum of two times. In those cases where a child was tested more than twice, the first and last testing was used to determine the effect of the program on the child. Each child's functioning level was established in years and months. By dividing this functioning level by the child's chronological age at the time of testing, a percentage of the norm value, or a functioning quotient, was obtained.

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MEAN PERCENTAGE * OF FUNCTIONING FOR FIRST AND LAST TESTING

	Social %	Cognitive Linguistic Verbal %	Gross Motor %	Fine Motor %	Eating %	Dressing %	Toileting %
Physically Handicapped							
1st Testing	78	76	38	64	79	57	67
2nd Testing	91	79	51	69	58	60	79
Slow Development Retarded							
1st Testing	52	39	50	48	57	51	52
2nd Testing	68	46	63	52	64	58	70
Speech and Hearing							
1st Testing	78	60	79	77	87	80	76
2nd Testing	82	77	81	81	80	86	92
Behavior and Emotional Problems							
1st Testing	99	76	90	81	89	65	80
2nd Testing	98	95	90	94	84	77	103
Multiply Handicapped							
1st Testing	28	26	19	21	20	21	41
2nd Testing	32	23	16	20	27	19	35
TOTALS							
1st Testing	57	46	49	49	59	57	59
2nd Testing	66	53	56	54	60	64	73

Figure 1

* Functional level divided by chronological age

For example, if a child with a chronological age of two years was functioning at age one year in the Gross Motor area, he would be at 50% of the norm value. By computing this percentage for each child at the time the child entered the program and then computing it again after the child had had the benefit of program participation, it was possible to see that for the most part children were able not only to maintain a level of functioning without falling further behind, but also to improve their level of functioning because of help received from the program.

Because the success of the 0-3 program has been demonstrated by the developmental gains of the participating children, it is felt that "An Inter-Disciplinary Approach to Early Education of Handicapped Children Ages 0-3 Years" will - as a model - be beneficial to those interested in providing similar services.

In order to better utilize materials presented in this notebook, a basic knowledge of the nature and background of the project as well as the comprehensive flow of service is essential to the reader.

Children in need of service have been referred through a variety of sources. Referral sources include: physicians; high risk nurseries; public service agencies; day care centers; state agencies; parents; and concerned individuals.

The process for total comprehensive evaluation, utilizing the team approach, begins with Intake which is the responsibility of the coordinator of social service. If the coordinator feels the child is in need of service, the case assignment is made jointly to a social worker and a child development worker who will both be responsible for working with the total family until the case is terminated.

During the first contact appointment the social worker meets with the family either in the home or at the center to take the case history, get releases signed, and to talk informally with the parents. The evaluation process begins at this time with the administration of the Functional Profile to the child by the child development worker. This tool was designed by the 0-3 project staff in order to assess a functioning level in the areas of social, cognitive, linguistic, gross and fine motor, eating, toileting, and dressing.

After the initial contact, the child development worker and the social worker discuss pertinent case details. It is following this meeting that the child development worker schedules appointments for the child's remaining evaluations. These include: a speech and language evaluation; audiometric screening; administration of the Denver Developmental Screening Test; and observation and/or evaluation by the consulting Psychologist.

Upon completion of the aforementioned evaluations, the child is scheduled for medical clinic. An important facet of medical clinic is the involvement of medical students for the purpose of enhancing their awareness of and insight into the needs of young children with handicaps. For, it is a major concern and goal of the 0-3 project to reach all individuals within the community who might aid in the early identification of young handicapped children.

The medical examination includes weighing and measuring of the child by a nurse, physical examination by the doctor, consultation with parent, and if necessary, referrals to other medical specialists.

After the medical evaluation, all children receive an occupational therapy and/or a physical therapy evaluation to more thoroughly evaluate functioning in the gross and fine motor areas. If necessary, the occupational and/or physical therapist (under the direction of a physiatrist) design wheel chairs and other adaptive equipment to aid in better positioning the child. This equipment is re-evaluated on a regular basis to determine continued need for the equipment and to insure proper fit as the child grows.

When all evaluations have been completed, the child development worker schedules a staffing. Individuals involved in staffing are those who have had direct contact with the child during the evaluation process or those who will be directly involved in program implementation.

Program options available to the child include: 0-3 Homebound Program; Public School Early Education Programs; Nursery Schools; other Agency Day Programs; Allied Agency's Developmental Training Program (if child is 2 years or older); Out-Patient Occupational Therapy; and Out-Patient Physical Therapy.

Staffing recommendations are discussed with the parents jointly by the child development worker and the social worker. It is felt by program staff that understanding and participation on the part of parents is a vital element in the success of the child's total program.

For those children participating in a homebound program, activities to facilitate development in areas of delay are taken into the home by the child development worker. Lessons are explained and demonstrated to the mother for it will be her responsibility to carry out the teaching procedures. The mother records the child's responses as a means for the child development worker to monitor and restructure the program to reach desired goals.

Because of the demonstrated gains of children participating in the program over the initial three year funding period, the co sponsoring agencies are now funded for replication and dissemination of the 0-3 Project. It is the purpose of Replication to assist other sites or agencies in developing programs to meet the individual needs of the 0-3 developmentally delayed child.

The services that are and will be available through Replication include:

1. Workshops to provide an in-depth knowledge of early intervention and identification techniques developed by the Peoria 0-3 Project.
2. Materials made available by mail to assist agencies in program development.
3. Training and consultation for participating agencies.
4. On-site consultation for follow-up.
5. Assistance in the evaluation of existing programs.
6. Development of joint programs with Universities to strengthen training of students in early identification and intervention techniques.
7. Workshops for implementing specific components of the 0-3 project in relationship to individual agency needs.

It is the feeling of the Replication Project Staff that only through cooperative efforts and sharing of ideas will the young handicapped child receive quality comprehensive service. The major thrust of Replication efforts, therefore, will be to share with interested agencies techniques and materials proven to be effective in dealing with the young handicapped population. If Replication can be of further assistance to you, please contact:

Replication Co-ordinator
Allied Agencies Center
320 E. Armstrong Avenue
Peoria, Illinois 61603

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PUBLIC AWARENESS

The information presented here is intended to help agencies beginning 0-3 programs to develop a functioning public awareness component. The following is considered to be essential in organizing and creating an effective public awareness network:

I. Identify the Need.

II. Initiate and Organize an Advisory Board.

  A. Board members

  Select knowledgeable people from the community as well as from agencies who have an interest in meeting the needs of the young handicapped child.

    1. Group
      - Division of Services for Crippled Children
      - Mental and Public Health Departments
      - School administrators (private and public)
      - Community Churches
      - Ethnic community groups
      - Social service agencies
      - Philanthropic groups

    2. Individuals
      - Director of Special Education
      - Pediatrician
      - Dentist
      - Parent
      - State or local government representative
      - Lawyer

  B. Function

  Instrumental in organizing and setting up:

    1. Board of Directors or voting membership

    2. Fund raising committee

    3. By-laws

III. Developing Program Awareness in Community

  A. Provide a visible model to the public to see.

  B. Stress that the program is to be a needed on-going community service, rather than a demonstration project.

  C. Utilize media to publicize the project.

  D. Contact your Chamber of Commerce as a resource agency.

E. Establish an open communication channel with community service.

F. If needed hire a part-time professional fund raiser on a consultant basis.

G. Procure support of church affiliated groups or agencies on a non-denominational basis.

H. Utilize available in-kind services throughout the community.

- space donated by area churches and public schools
- medical and dental services provided by Public Health Clinics
- Department of Mental Health testing donated for various screening and psychological evaluations
- full tuition scholarships provided by community groups
- volunteer services provided through Governmental Sponsored Volunteer Corps, room aides, transportation, and Clinical assistance
- program workers provided through community action Agency Youth Corp

IV. Utilize professional fund raiser

A. Through consultant funds

B. On a part-time basis

Sources for Funding

State Departments of Mental Health

State Developmental Disabilities Programs - often funded through Mental Health

Levied tax funds

Bureau of Education for Handicapped

State Offices of Public Instruction - 2671

Local Social Service groups - Name and address

United Fund Agencies

County Boards for the care and treatment of Mentally Deficient Persons

Revenue sharing 4-A funds

Tuition basis

Departments of Public Aid

Departments of Public Health

Departments of Children and Family Services

Division of Services for Crippled Children

(fund direct service therapy)

Private non-profit agencies - Examples:

Easter Seal Society

United Cerebral Palsy

Associations for Retarded Citizens, Inc.

Churches

Get clients before staff/coincide units of service

The cost for funding a program for developmentally delayed children ages 0-3 would vary depending on a number of factors. Some of the influencing factors to keep in mind are:

1. The number of students to be served.
2. The type of program (i.e. - homebound or day program).
3. Wage rates depending upon the geographic location of the program.
4. The geographic location of student population if providing homebound program.
5. Types of out-patient services that would be made available.
6. The number of staff persons to be utilized.
7. Donated or in-kind services such as volunteer workers, donated space, donated materials.
8. Kinds of adaptive equipment needed to serve the population of children.

The enclosed worksheets have been designed to assist agencies in projecting the costs of beginning a 0-3 program for homebound. Many agencies will already have some existing resources which would cut down considerably on the initial expenditures. The worksheets include all items which would be considered as needed for an ideal program arrangement. Those items which have an asterisk indicate the minimum services which would be essential to begin a program.

The needs outlined are for planning a population of 20-30 students. Please note that the cost an agency might compile for 20 children would not necessarily double if, for example, 40 children were to be served, because many costs would remain constant. The space needs, administrative, and secretarial needs would most likely remain the same. While it would be necessary to hire an additional child development worker for serving 40 children.

The services and equipment needed for a homebound program are listed on the worksheets. The blank spaces are for the individual agency to list their cost per item. The totals of all items would give a projected cost to begin a program.

HOMEBOUND WORKSHEET

STAFF	PERCENT/TIME	COST
*Occupational Therapist	25	
Physical Therapist	25	
Program Supervisor	25	
*Child Development Specialist	100	
Speech and Language Therapist	25	
Registered Nurse	10	
Home Program Enabler	50	
*Pediatric Consultant	20	
Physiatrist	Hourly basis as needed	
Orthopedist	Hourly basis as needed	
Social Worker	25	
Psychiatrist	Hourly basis as needed	
Behavior Mod. Consultant	5	
Administration & Bookkeeping	25	

EQUIPMENT

TRAVEL

Child Development Worker	10¢ a mile	
Enabler	10¢ a mile	

Totals (Page 1)

SUPPLIES AND MATERIALS	COSTS
Instructional	
1. Small hand mirrors	
2. Rattles, noise-making toys	
3. Pictures of common objects and animals	
4. Small bells	
5. Balls	
6. Musical toys - such as toy radios	
7. Variety of textures	
8. 1-4 piece puzzles	
9. Small blocks (and large blocks)	
10. Stacking cups and/or rings	
11. Peg board	
12. Small boxes and/or cans	
13. Straw bottles	
14. Puppets	
15. Pinwheels	
16. Small drums	
17. Beads and lace	
18. Children's blunt scissors	
19. Crayons	
20. Clothespins - pinch and regular	
21. Tubes - paper or plastic	
22. Beach balls - various sizes	
23. Jack-in-the-box	
24. Balloons	
25. Toy cars	
26. Form board (○, □ , and △)	
27. Bottle (small to medium opening)	
28. Medium or small size doll	
29. Set of 4 matching pictures	
30. Toy telephone	
31. Plastic fruit	
32. Playdough	
33. Squeak-A-Boo (Fisher Price)	
34. Functional Profile	
OFFICES	
COMMUNICATION	
Postage	
Telephone	
SPACE	
Space for Child Development Worker	
Space for Diagnostics	
Space for Administration and Accounting	
Totals (Page 2)	
Totals (Pages 1 & 2)	

Projected Cost to
Originate Program

DAY PROGRAM

Some agencies will want to plan classes for children over age two in their existing day programs. Others may be providing only 0-3 services and also may want to open a classroom section. The worksheets provided for a day program include all items that would be recommended for an ideal program setting. The essential staff, etc. is marked with an asterisk.

The projections and staff percentages are based on a five day week, five hour day program serving 15-18 children. If an agency would not have sufficient funds for a full day program other alternatives would include a five day week, half day program, or a two to three day a week, half day program. (Note: Often if funds come from state agencies the program must be a five day a week, five hour a day program.)

A day program for 0-3 can be operated in conjunction with a homebound program in which case many of the staff needs would overlap.

The services and equipment needed for a homebound program are listed on the worksheets. The blank spaces are for the individual agency to list their cost per item. The totals of all items would give a projected cost to begin a program.

DAY PROGRAM WORKSHEET

PERSONNEL	PERCENTAGE OF TIME	COST
*Head Teacher	100	
Assistant Teacher	100	
*Teacher Aide	100	
*Social Worker	25	
*Occupational Therapist	25	
Physical Therapist	25	
Program Supervisor (In some cases Program Supervisor might be same person as head teacher)	12	
Nurse	12	
Speech and Language Therapist	25	
Administration and Bookkeeping	12	
Bus Driver		
Cook		

SPACE

1 - Classroom (35' X 40')
Space for Administration & Bookkeeping
Kitchen Space

LUNCH COSTS

Preparation on site
Contracted

EQUIPMENT (See Beckley - Cardy Catalog)

2 - low movable storage unit
2 - large movable storage unit
3 - Cribs
3 - Mattresses
3 - Playpens
3 - High chairs
Stand-up table
1 - Carpeted spool
6 - Cots
4 - Small folding chairs

Page 1 Totals

EQUIPMENT (CONTINUED)	COST
8 - Small Chairs	
2 - Small Tables	
1 - Record Player	
2 - Potty Chairs	
1 - Large Table	
1 - Rocking Horse Toy	
18 - Quilts and/or blankets (washable)	
15 - Small pillows	
TOYS	
2 - Pull toys	
3 - Stacking rings	
2 - Chatter Phones	
2 - Tamborines	
2 - Busy Boxes	
1 - Surprise Box	
4 - 5 Balls	
1 - Shapo Game	
2 - 3 Sets Plastic Blocks	
3 - Shape Mail Box	
5 - 6 Musical Toys	
1 - Jack-in-the-Box	
3 - Peg Boards	
3 - Sets Pegs	
2 - Stacking cup sets	
3 - Sets Moroccas	
1 - Drum	
3 - 4 Shape puzzles	
3 - Texture Board Cards	
10 - Sheets	
18 - Bibs (plastic or cloth)	
14 - Plastic cups	
1 - Medicine Box with lock	
6 - Plastic straw bottles	
6 - Bib chains	
Assorted silverware	
Adapted spoons	
Garbage can	
5 - 7 Sand bags	
1 - 2 Walkers	
1 - Wagon	
1 - Jump swing	
1 - 2 rolls for therapy	
1 - Swing for small children	
2 - Adapted tires for therapy	
1 - Stand-up mirror	
1 - First-Aid Kit	
1 - Warming Oven	
Books	

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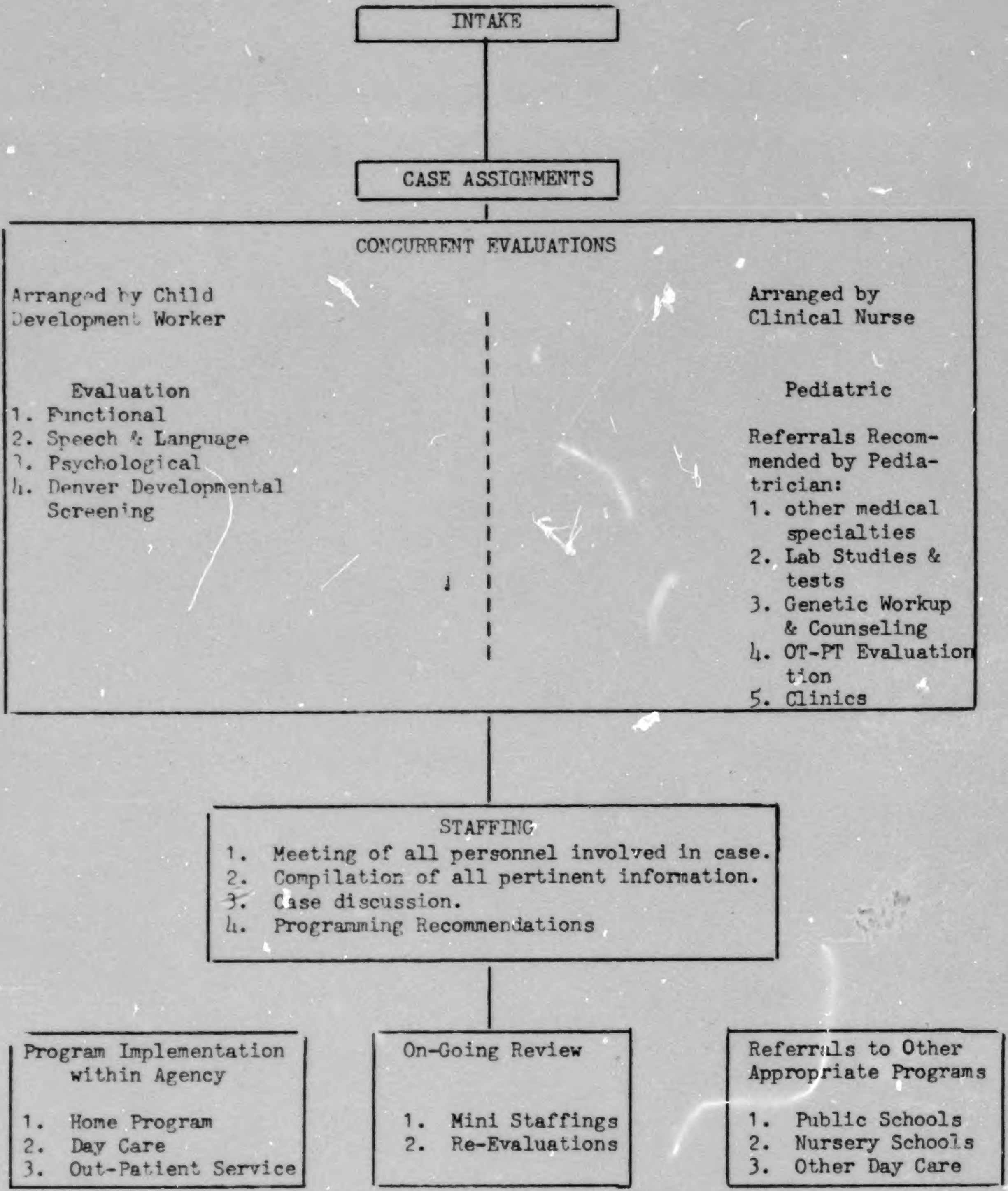
Page 2 Totals ____________

TRANSPORTATION	COST
Contracted	____________________
Purchase Vehicle	____________________
Mileage for Drivers (use own car)	____________________
Volunteer	____________________
Totals Page 3	____________________
Totals Pages 1, 2,& 3	____________________ Approximate Cost to Begin Program



INTAKE

CASE ASSIGNMENTS

CONCURRENT EVALUATIONS

Arranged by Child Development Worker

Evaluation
1. Functional
2. Speech & Language
3. Psychological
4. Denver Developmental Screening

Arranged by Clinical Nurse

Pediatric

Referrals Recommended by Pediatrician:
1. other medical specialties
2. Lab Studies & tests
3. Genetic Workup & Counseling
4. OT-PT Evaluation tion
5. Clinics

STAFFING
1. Meeting of all personnel involved in case.
2. Compilation of all pertinent information.
3. Case discussion.
4. Programming Recommendations

Program Implementation within Agency
1. Home Program
2. Day Care
3. Out-Patient Service

On-Going Review
1. Mini Staffings
2. Re-Evaluations

Referrals to Other Appropriate Programs
1. Public Schools
2. Nursery Schools
3. Other Day Care

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ALLIED AGENCIES DEVELOPMENTAL TRAINING PROGRAM

Co-sponsored By
Peoria Assn. for Retarded Citizens, Inc. & United Cerebral Palsy of Northwestern Ill.
Allied Agencies Center - 320 East Armstrong Ave. - Peoria, Illinois 61603

EVALUATION SUMMARY SHEET

Child: B/D: Age:
Parents:
Address:

Referred by: Physician:

Presenting Problem:	Presenting Problem: Age:
Diagnosis:	Diagnosis:
Medical Evaluation: Date:	Medical Evaluation: Date:
Physical Therapy/Occupational Therapy: Date: Age:	Physical Therapy/Occupational Therapy: Date: Age:
Denver Developmental Screening Test: Date: Age: Personal-Social: Fine Motor, Adaptive: Language: Gross Motor: Summary:	Denver Developmental Screening Test: Date: Age: Personal-Social: Fine Motor, Adaptive: Language: Gross Motor: Summary:
Functional Profile: Date: Age: Social: Cognitive-Linguistic: Gross Motor: Fine Motor: Eating: Dressing: Toileting:	Functional Profile: Date: Age: Social: Cognitive-Linguistic: Gross Motor: Fine Motor: Eating: Dressing: Toileting:
Psychological: Date: Age:	Psychological: Date: Age:
Speech and Language: Date: Age:	Speech and Language: Date: Age:

(This page has been reduced for the manual. Legal size paper is normally used for the Evaluation Summary Sheet.)

********************** STAFFING RECOMMENDATIONS ON BACK **********************

The social worker serves as the initial contact between parents and the services provided by the 0-3 program. Through the social worker's efforts, all children considered for program are channelled to the appropriate staff and/or consultants for evaluation in order to provide comprehensive diagnostic services to meet the individual needs of the child. The social worker continues to function as a viable link between parents and program by providing explanations to parents concerning diagnostic recommendations and by providing follow-up to determine if recommendations have been appropriately carried out.

The Social Worker in correlation with the Peoria 0-3 Project, Peoria, Ill.

I. Rationale
- (a) To help parents accept their child's developmental disability.
- (b) To aid parents in understanding how the child's individual needs may be met.
- (c) To find an appropriate program for each child so that he may develop to his maximum potential.

II. Referral
- (a) A referral is received by the agency and the initial contact with the family is made by the head Social Worker.
  Referrals come from:
    1. Physicians and Pediatricians
    2. Public Health Nurses
    3. Nursery Schools and Head Start Programs
    4. Social Workers and Social Service Agencies
    5. Hospitals
    6. Concerned People

- (b) The Head Social Worker starts an intake sheet on the family and determines if the case should be pursued. Information on the intake sheet includes:
    1. General information, name, address, birthdate, school district, employment, etc.
    2. Family medical history
    3. Birth History
    4. Child's Early Development
    5. Child's health history

  Other legal forms to be filled out:
    1. Medical release form to be signed by parent or guardian and witnessed.
    2. Department of Mental Health Social Service Financial form
    3. A release form for transportation, field trips, pictures, T.V., educational journals, and medication signed by parent or guardian and witnessed.
- (c) If a case is to be opened the Head Social Worker then selects a social worker whom she thinks will best fit the family. She then sets up an interview and continues gathering information on the child and family.
- (d) If a homebound program is indicated the social worker contacts a child development worker and together they make appointments for the child to receive an in-depth evaluation to include:
    1. A Functional Profile (Child Development Worker)
    2. Denver Developmental (Nurse)
    3. Speech Evaluation (Speech Therapist)
    4. Medical Clinic (Medical Specialist)
    5. OT/PT Evaluation (when indicated) (Occupational and Physical Therapist)
    6. Psychological (Children over 2½ years) (Psychologist)

(e) After the evaluation is completed, this may take eight weeks or more, the parents are called in for a conference with the Social Worker and Child Development Worker. The results of the evaluation are explained along with a plan or program of ways they may help their child's development. When indicated, at this point a home program is initiated, and the Child Development Worker continues her contact with the family. The Social Worker remains in the background with only occasional visits at first. When the Child Development Worker has a good rapport with family and child, the Social Worker phases out and only reviews the case for re-evaluations until case is closed.

III. Social Service Suggestions from the Head Social Worker:

1. Be sure intake sheet has father's legal name, not just husband's name. This might be a foster child, or there may be a different father in the home.
2. Financial information must be filled out in order to receive Department of Mental Health funding.
3. Be sure and find out who is caring for the child. You might need to make contacts with babysitter. In some cases, Home Program is delivered to a sitters home.
4. When giving the results of an evaluation to parents, remember to tell them something good first.
5. If possible your waiting room facility should be one where there is some privacy and allows for some parents to chit-chat with each other, but also if they do not wish to do that, there is a place for them to sit with some privacy.

The occupational and physical therapy program for the motorically involved child is an important component of the homebound program. The following provides a brief description.

I. Rationale Purpose

A. To aid the developmentally delayed child in areas of gross and fine motor by the use of therapy and adaptive devices.

B. To provide parental insight into the purposes of and the need for adaptive devices and occupational therapy.

C. To prescribe a program for reinforcement of motor activities in the home.

II. Procedure

A. A physiatrist or attending physician writes a prescription for developmental evaluation to be done by either the occupational or physical therapist. (See Appendix for example of evaluation recording form).

B. The child is scheduled for evaluation at Physiatric Clinic.

C. The physiatrist examines the child and writes a prescription for therapy as well as adaptive devices when appropriate.

D. The occupational or physical therapist evaluates the child to determine the level of his developmental delay.(See Appendix Ia, Ib for form example).

E. An appropriate program is implemented to stimulate motor development.

III. Developmental Therapist in 0-3 Program

A. The occupational therapist evaluates and generally does theraputic work with upper parts of the body. This person also recommends motor activities to enhance intellectual growth.

B. The physical therapist in 0-3 program evaluates and provides theraputics for the lower extremities.

C. Adaptations such as wheel chairs, shoes, feeding devices, etc. are done by either therapist.

D. In the 0-3 program they work as a developmental theraputic team, and their positions are interchangeable.

IV. Program

A. Children are brought to the therapy room from the classrooms 3-5 times a week for ½ hour sessions.

B. Programs are individualized for each child, and data is posted.

C. Prerequisite skills are taught when indicated according to each child's individual needs. (See example prerequisite lesson plan in Appendix IIa).

D. They provide therapy and written O.T. - P.T. lesson plans for use by the teacher in the classroom.

E. Children are also brought to the program on an out-patient basis and are seen 1 or 2 times weekly for a one half hour session.

F. One or both parents accompany the child and are given plans and demonstration techniques of theraputics that can be used to enhance and stimulate development in the home.

G. Parent groups workshops are also held periodically by the therapists and various consultants to further the parents' understanding of their child's development.

APPENDIX Ia
ALLIED AGENCIES DEVELOPMENTAL TRAINING PROGRAM
Co-sponsored By
Peoria Assn. for Retarded Citizens, Inc. & United Cerebral Palsy of Northwestern Ill.
Allied Agencies Center - 320 East Armstrong Ave. - Peoria, Illinois 61603

PHYSICAL THERAPY EVALUATION

	Gross Motor Age	Date	Evaluator
Client's Name	1.		
Birthdate	2.		
Diagnosis	3.		
	4.		

I. Predominant Muscle Tone
- A. Flaccid
- B. Hypotonic
- C. Hypertonic
- D. Hyperkinetic
- E. Normal

II. Limitations in Range of Motion

III. Reflexes and Reactions

A. Spinal level (0-2 months)
- 1. Flexor withdrawn
- 2. Extensor thrust
- 3. Crossed extension
- 4. Grasp reflex

B. Brain Stem Level (0-6 months)
- 1. Rooting (0-2 mos.)
- 2. Sucking (0-2 mos.)
- 3. Asymmetrical
- 4. Symmetrical
- 5. Tonic labyrinthine supine
- 6. Tonic labyrinthine prone
- 7. Associated reactions
- 8. Positive supporting reaction
- 9. Negative supporting reaction

C. Automatic Movement Reactions
- 1. Moro reflex (0-6 mos.)
- 2. Landau (6 mos. - 2½ yrs.)
- 3. Protective extensor thrust (6 mos. - life)

D. Midbrain level
- 1. Head raising righting reactions labyrinthine
  - a. Prone (1-2 mos. through life)
  - b. Supine (4-6 mos. - life)
  - c. Lateralization (7 mos. - life)
- 2. Head Raising, optical righting
  - a. Prone (1-2 mos. through life)
  - b. Supine (6 mos. - life)

3. Roll Over (neck righting 0-6 mos., body righting 6 mos-life)

a. Supine-side (1-4 wks.)					
1. Right					
2. Left					
b. Prone-Supine (mos.)					
1. Right					
2. Left					
c. Supine-Prone (8 mos.					
1. Right					
2. Left					

IV. Gross Motor Function
(Midbrain Level Continued)

A. Pivot prone pattern

1. Knees extended					
2. Knees flexed					

B. Neck co-contration pattern				

C. Prone on elbows pattern-Belly crawling 7-8 mos.

1. Pushing back				
2. Pulling forward				
3. Turning				

D. Amphibian Reaction (6 mos.)				

(Cortical Level)

E. Creeping-all fours				
1. Assumes				
2. Maintains				
3. Shifts weight				
4. Equilibrium				
5. Pattern				
a. none				
b. Homologous				
c. Homolateral				
d. Reciprocal				
F. Sitting				
1. Maintains (7 mos.)				
2. Assumes (10-12 mos.)				
3. Equilibrium				
G. Standing				
1. Assumes (10½ mos.)				
2. Maintains				
3. Shifts weight				
4. Equilibrium				
5. Dorsiflexion				
H. Walks (15-18 mos.)				
1. Cruising				
2. Arms used for balance				
3. Reciprocal pattern				
4. Runs (30 mos.)				

V. Breathing

VI. Comments:

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Adapted from: Fiorentino and Gessell

OCCUPATIONAL THERAPY EVALUATION

Key	Tester	Date
I--Independent H--Can do with help A--Attempted No-Unable		

SUMMARY

DEVELOPMENTAL EVALUATION - GESELL

AGE	AREA OF FUNCTION					BEHAVIORAL CHARACTERISTICS
3 Months	Feeding					Lip Pressure Co-coordination of sucking and swallowing
4 Months 16 Weeks	Motor					Head Control: Sup.--moves from side to side Prone--raises head perpendicular to floor Pull to sit--slight head lag Symmetrical hand and arm positions in supine (near face or chest) Follows ring 180° --midline regard Holds toy actively (grasp reflex not completely gone) Outside fingers strongest
	Adaptive					Arms activate on sight of toy
20 Weeks	Motor					Definite approach movements resulting in contact with objects. Bilateral approach, arms move in unison.
6 Months	Feeding					Hand to mouth
7 Months 28 Weeks	Motor					Rolls from supine to prone Sits alone - 1 min. (trunk erect, with support of hands) Pulls to sit--no head lag Grasps cubes, palmar-wise, thumb participates
	Adaptive					Unilateral approach (no established laterality)

	Adaptive (Cont.)					Transfer objects and mouths objects Holds one, grasps another-cube Resecures object after dropping Bangs toys Pats image in mirror--easily distracted
32 Weeks	Motor					Inferior scissor grasp; thumb to 1 side of index finger
9 Months	Feeding					Can protrude tongue Lateral motions of tongue Feeds self crackers (munching instead of sucking)
10 Months 40 Weeks	Motor					Creeps Sits alone-pivots Sits alone-10min. plus Supports full weight with railing Well coordinated reaching for near objects Opposed grasp-inferior pince grasp between thumb and top of index and middle fingers Crude release (drop) just emerging
	Adaptive 375					Hits-pushes cubes together

	Adaptive (Cont.)					Pulls the ring
						Extends index finger and pokes objects
44 Weeks	Motor					Neat pincer grasp with extension of wrist
Year 1 52 Weeks	Motor					Cruises
						Walks with one hand held
						Neat pincer grasp (pellet 13' away in midline)
						Voluntary release
	Adaptive					Able to grasp 2 cubes in 1 hand
						Puts cube in container (demon.)
						Brings one block over another (tried tower, may fall)
						Dangles ring by string
	Dressing					Co-operates (puts foot out for shoe, arm for sleeve)
	Feeding					Grasps spoon, picks up from table
						Chews food
						Drooling controlled at all times,
						Drinks mild from cup if held for him
15 Months	Motor					Walks without support - few steps, stops and starts

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	Motor (Cont.)					Stairs: Creeps up full flight
						Pellet: Places in bottle (comm., gesture, spontan.)
	Adaptive					Cubes: tower of two (demon.)
						Cup and cubes: 6 in and out
						Drawing: incipient imitation stroke
						Formboard: places round block after demon.
18 Months	Motor					Walks fast, seldom falls
						Stairs: up and down, one hand held (3 steps, riser 6.5", tread 11")
						Walks pulling toy
						Knee high chair; seats self without climbing up
						Adult chair: climbs into
						Maintains wide open hand until toy is reached
	Adaptive					Cubes: tower of 3 or 4
						Crude release
						Cup and cubes: 10 into cup (spontan. or with urging)
	Feeding					Drinks from cup
						Feeds self but messy
	Dressing					Removes socks

18 Months (Cont.)	Adaptive					Drawing: scribbles spontaneously
						Drawing imitates vertical stroke
						Formboard: spontan. piles 3 blocks
2 Years	Motor					Walks with heel-toe progression
						Runs without falling
						Squats to play
						Stairs: up and down alone (railing OK)
						Book: turns pages singly
						Throws ball accurately
						Ball: kicks (command or demon.)
	Adaptive					Cubes: tower of 6 to 7 eye-hand coordination crudely integrated
						Cubes: align 2 or more for train (demon.)
						Drawing: imitates V stroke
						Drawing: imitates circular stroke
						Strings beads (1")
	Feeding					Spoon to mouth
						Drinks from cup and glass (one handed)
	375					Drinks from straw

2½ Years	Motor					Jumps with both feet in place
						Walks between lines 8" apart without stepping on them
						Holds crayon by opposition
	Adaptive					Cubes: tower of 8
						Drawing: 2 strokes for cross (anywhere)
						Drawing: imitates H stroke
						Formboard: adapts repeatedly, with error
3 Years 36 Months	Motor					Walks a straight line (1/8')
						Stairs: alternates feet going up
						Rides tricycle using pedals
						Stands on one foot, momentary balance
						Jumps down 12" without help (two feet at once
	Adaptive					Cubes: tower of 9 (10 on 3 trials) (no demon.)
						Cubes: imitates bridge
						Pellets: 10 into bottle (in 30sec.)
						Drawing: names own drawing (spontan. or on request)
						Drawing: copies circles
						Geometric forms: points to 4

3 Years 36 Months	Adaptive (Cont.)					Formboard: adaption without error (immediate correction - OK)
	Feeding					Feeds self without much spilling
	Dressing					Dresses and undresses with supervision except small back fastenings
						Unlaces shoes
						Learning to lace shoes
						Puts on shoes, not necessarily on correct foot
						Washes and dries hands but not thoroughly
						Bowel and bladder control day and night
						Brushes teeth, supervised
3½ years	Motor					Stands on 1 foot, 2 sec.
	Adaptive					Drawing: traces diamond
						Cubes: builds bridge from model
						Geometric forms: points to 6
4 Years 48 Months	Motor					Stairs: walks down, last few steps a foot to a step
						Skips: on 1 foot
						Jumps: running or standing broad jump (23" - 33")
						Pincer grasp

4 Years	Motor (cont.)					Stands: on 1 foot, 4-8 sec.
						Exaggerated extension of trunk still present
	Adaptive					Pellets: 10 in bottle in 25 sec.
						Cubes: builds gate (demon.)
						Drawing: man with 2 parts
						Drawing: copies across
						Paper: folds and creases 3 times (demon.)
						Geometric forms: points to 8
						Counts: with correct pointing 3 objects
	Feeding					Feeds self with fork
						Drinks through paper straw without mashing
	Dressing					Puts shoes on correct feet
						Laces shoes
						Dresses - knows back and front of clothes
						Washes and dries face
						Brushes or combs hair,
						Brushes teeth
						Manages buttons on self
4½ Years	Motor					Hops: on 1 foot

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4½ Years	Adaptive					Drawing: traces cross
						Drawing: copies square
						Geometric forms: points to 9
						Cubes: copies gate
						Counts: with correct pointing, 4 objects
5 Years 60 Months	Motor					Skips: using feet alternately
						Release: smooth release with slight extension of metacarpal and phalangial joints
						Stands: 1 foot, 8 sec.
						Cube: held by (R) hand corner so view is clear
	Adaptive					Cubes: builds 2 steps (demon. 4 steps)
						Drawing: Unmistakable man with body, arms, legs, feet, mouth, nose, and eyes
						Drawing: copies rectangle with diagonals (66 mos.)
						Pellets: 10 into bottle in 20 sec.
						Uses scissors
						Follows line
						Counts 12 objects with correct pointing (66 mos.)

	Dressing					Dresses self completely except for buttons and bows in back
						Helps bathe self
6 Years	Motor					Jumps: from 12" and land on toes
						Stands: on each foot alt., eyes closed
	Adaptive					Cubes: builds 3 steps
						Drawing: man has neck, hands on arms, and clothes
						Drawing: copies diamond
						Counts: correct no. fingers on single hand and total without counting
						Adds and subtracts within five
						Copies printing
	Feeding					Cuts with knife and fork
	Dressing					Buttons small buttons on own shirt
						Ties bows on shoes
						Combs and brushes hair successfully
						Cleans and blows nose
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FEEDING:

1. Chewing
2. Sucking
3. Drooling
4. Tongue thrust
5. Mouth closure

EYES:

1. Converge
2. Tract vertically, horizontally, circle, together

REFLEXES:

COMMENTS:

APPENDIX IIa

FOR CLASSROOM USE ONLY
#3010a
Page 1 of 1

DEVELOPED BY
PROJECT E.A.R.N.
8/7/74
Revised

MOTOR - MOVING THE HEAD FROM SIDE TO SIDE

Terminal Performance:

Given the instruction, "(Pupil's name), turn your head from side to side, please," the pupil will move his head from side to side in 30 seconds or less without any additional verbal instruction or assistance.

Object of Tutoring:

1. Appropriate reinforcer (s) -- optional.
2. One extra person either a teacher or staff member (preferably the teacher) must be present beginning at level 7 - optional (for generalization procedure).

Prerequisite Skills:

1. Must be able to move his head, just slightly.

Order of Instructions:

1. The verbal instruction to be used is, "(Pupil's name), turn your head from side to side, please."
2. Follow General Format for Tutoring when dealing with correct and incorrect responding.

Levels:

1- The pupil makes any attempt to move his head.

2- The pupil turns his head halfway to the right or left.

3- The pupil turns his head completely to the right or left.

4- The pupil turns his head completely to one side then back to a front view.

5- The pupil turns his head completely to one side and halfway to the other side.

6- The pupil turns his head completely to one side and then completely to the other side.

7- Optional - continue with program 0030 (Generalization).

DENVER DEVELOPMENTAL SCREENING TEST

I. Purpose

To Provide:

A. A standardized screening instrument to detect developmental delays from infancy through six years.

B. An evaluation tool that can be administered by individuals who have not had special training in psychological testing.

II. Standardization

A. Over a dozen infant developmental tests and preschool intelligence tests were surveyed to select test items.

  1. Criteria for the item selection included the following:
     -the amount of equipment required for administration
     -ease of administration
     -clarity of scoring
     -relatively short distribution (i.e. brief time between the age at which the children begin to do the task and the age at which most of the sample could do the task).

B. The population utilized for standardization was comprised of 1036 normal Denver children ranging in age from 2 weeks to 6.4 years (343 males, 493 females).

  1. Subjects reflected racio-ethnic and occupational group characteristics of the Denver population according to the 1960 census.

III. Format

A. The test is comprised of 105 items written in the range of accomplishments of children in the age span from birth to six years.

B. Areas of development assessed include:

  1. Personal - Social --tasks which indicate the child's level of participation in developing and interpersonal relationships as well as development of self care skills.
  2. Fine Motor - Adaptive --tasks which indicate the child's ability to use his hands to pick up objects and to draw.
  3. Language --tasks which assess the child's ability to hear, carry out commands, and to speak.
  4. Gross Motor --tasks which assess the child's ability to sit, walk, and jump.

C. Administration and scoring instructions are provided for each developmental task.

IV. Availability

A. The DDST as well as a training tape for administration is available through your local Mead Johnson Pharmaceutical Representative. All are free of charge at:

Mead Johnson Company
2404 Pennsylvania
Evansville, Indiana 47721

A NEW WAY OF TESTING CHILDREN'S EARS

Introduction

An eminent northern Ear, Nose, and Throat Consultant tells a true story of his days as a junior hospital doctor, some twenty years ago. A mother brought her seventh and youngest child to the hospital to have his ears examined. "There is something wrong with them" she complained. A very thorough examination revealed nothing abnormal; the child responded to sound and the physical appearance of the ears was perfect. The doctor informed the mother accordingly. "No!" she insisted, "There must be something wrong". The young man was intrigued, and asked the mother why she was so sure there was something amiss. "Well," she said "My ears run, my husbands' ears run. His six brothers and sisters all have running ears. He is the only one of the family whose ears don't run. So there must be something wrong with them!"

This story serves to illustrate what conditions were like around a generation ago. Running ears were commonplace, both in adults and children, and many of them required mastoid surgery. Severe loss of hearing was an all too common result. No infrequently life itself was endangered. Nowadays the picture is very different; discharging ears are relatively less common, and few of those seen now require mastoid surgery. The operation itself has lost much of its fearsome reputation.

But, as so often seems to happen in medicine, as one problem disappears another replaces it. Acute inflammation has diminished, but for some years awareness has been growing of a problem in children in which fluid develops in the middle ear cavity. This is not entirely a new condition, having been observed and recorded over a hundred years ago, but there seems little doubt that it is on the increase. One of the major problems associated with middle ear fluid is that of diagnosis, and relative to this I would like to quote from the remarks of a leading London surgeon at an International Congress on Audiology. He said, "Diagnosis of this condition is not always easy... the anxiety of parents is quickly allayed when the earache stops and the temperature comes down after an attack of acute otitis media. Under the favorable conditions of the home the hearing may appear to be perfectly adequate, but little by little suspicions are aroused... the child seems inattentive or the teacher may notice he is falling back at school. When it comes to his ears the changes in the drum head may be so slight that we may easily miss them unless we exercise constant vigilance. Only 18 out of 48 established "glue" ears showed unequivocal signs of fluid on careful inspection of the membranes with an auriscope; and the hearing may bear little relationship to the appearance of the membrane."

A skilled observer in this instance was able to identify only 18 out of 48 cases on the basis of a physical examination. This is less than 40%. The conventional method of testing hearing using an audiometer fares no better for two reasons. In this condition we are predominantly dealing with the young child aged from four to seven or eight years. The decision we ask of that child, whether a sound is just inaudible, requires a degree of judgement that may often be beyond his years.

Secondly, where the fluid in the middle ear is thin and watery, as it frequently is when first formed, the associated hearing loss may be very slight; too slight to be regarded as significant by normal standards.

It may be asked then as to why, if the hearing loss is so slight, there is any need to be concerned about detection. Wherein lies the handicap? Is there any real need to bother about the problem? There are two aspects to this condition, an educational one and a medical one. Ling (1) has shown that even very small losses of hearing may set a child back in the fundamental subjects such as English and Arithmetic. Thus, a child may be educationally retarded during the first vital years at school. Secondly,although in the initial stages the hearing loss may be but slight, the disorder tends to be progressive, and the loss of hearing to increase. Middle ear fluid is without doubt the main cause of conductive deafness in children. In Carter's series of children with conductive deafness in Stoke on Trent/90% had this condition (2). Smith of York reported 80% (3), and Wehrs and Proud in Kansas found virtually 100% (4). Furthermore, the longer it is before the abnormality is detected the more difficult its resolution becomes. Thus, there is every reason to try to detect and deal with middle ear fluid at its earliest possible stage.

On the evidence adduced, conventional methods of detection do not appear to be satisfactory. A new method is needed which should meet certain requirements. The indications of the test should not depend to any degree on the cooperation of the child being tested, but rather, the assessment of function should be entirely in the hands of the tester. The test should be simple, reliable, and acceptable to even the very young child.

Such a test is now possible using a device called an Acoustic Impedance Bridge.

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(1) Ling, D., 1959. Education and background of children with defective hearing. Unpublished research thesis. Cambridge.

(2) Carter, B.S., 1963. Proc. Roy. Soc. Med. 56. 699.

(3) Smith, C., 1964. Proc. Roy. Soc. Med. 57. 766.

(4) Wehrs, R.E. & Proud, G.O. 1958. Arch. Otolaryng. 67. 16.

ACOUSTIC IMPEDANCE

When a sound wave enters the ear canal it progresses inwards until it reaches the tympanic membrane or as it is more commonly called, the eardrum. Some of the sound energy is reflected back from the drum and the remainder sets it into vibration. This vibration is transmitted through the chain of bones in the middle ear, the ossicles, to the inner ear where the true process of hearing commences. Normally the middle ear is highly efficient. Little sound is reflected by the eardrum, the major part of the energy passing on as vibration to stimulate the inner ear. If the middle ear system alters, for example as a result of the disease, the proportion of the original sound transmitted through it may alter. The reflection at the eardrum will be increased if the middle ear becomes less mobile.

The Acoustic Impedance of the middle ear is the term used to describe the opposition or the hindrance rendered by the middle ear to the passage of sound. The impedance is determined by measuring the amplitudes of the incident and reflected sound waves. A probe is inserted into the ear canal in such a way that an airtight seal is obtained. (With children there is very little difficulty in carrying this out as the walls of the ear canal are soft and flexible. With adults there may be a little more difficulty, but in over five thousand cases less than 5% have proved difficult, and less than 0-1% impossible to seal.) Connected to the probe are three tubes. A tone of 220 HZ (just below middle C) produced by an osillator and miniature telephone is introduced into the ear canal along one of these tubes. The level of sound in the cavity is measured by a microphone connected to a second tube, and displayed on the meter. The third tube is connected to a small pump and pressure gauge. By this means small, accurately measured variations of pressure can be introduced into the ear canal. Normally the pressure in the middle ear is the same as the external pressure, the eustachian tube having the function of equating the middle ear pressure to atmospheric pressure. If a positive pressure is exerted on a normal tympanic membrane, it will produce a stretching of the drum, forcing it to bulge inwards. This will reduce the mobility of the drum, and enhance the reflection. The Acoustic Impedance will rise. An overpressure of about ½% is sufficient to double the impedance, to reduce the mobility by 50%. If the applied pressure is increased to 2% the drum becomes effectively rigid, and further increase of pressure produces virtually no change in the impedance.

The application of positive pressure in the ear canal has the same effect as a reduction of pressure in the middle ear cavity. Such a condition is frequently met with in disorders of the middle ear. Upper respiratory infection, such as may come from the common cold, produces inflammation of the lymphatic tissues of the nasopharynx. In a young child the adenoids are the most frequent site of inflammation, and the swelling of these tissues obstructs the mouth of the eustachian tube reducing or inhibiting its ability to equalize the pressure in the middle ear. If the tube is completely obstructed the middle ear becomes a closed cavity. Absorption of the air within the cavity takes place, and a partial vacuum is formed. This produces a retraction of the drum with

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the same stiffening effect as positive pressure in the ear canal. The acoustic impedance is raised. Increased impedance may also arise as a result of pathological changes in the middle ear. Otosclerosis is a common disorder which affects the mobility of the ossicles. A bony overgrowth reduces the ability of the stapes to vibrate, and this results in a stiffening of the whole chain of bones, and an increase in the impedance.

If, therefore, a single reading only of the mobility of the middle ear system is made, with normal atmospheric pressure in the external ear canal, the result may be misleading. It may indicate high impedance, leading one to think of a pathological condition such as otosclerosis, whereas the stiffness may be due only to a slight reduction of the middle ear pressure with a retraction of the drum. By making measurements at different pressures, an assessment of the middle ear pressure can be made, and the effects of any pressure reduction eliminated. In practice, a curve is obtained showing the variation of middle ear mobility as a function of the pressure applied in the external ear canal. This curve normally has a sharp peak at the point where the air pressures on each side of the eardrum are equal, for at this point the membrane is unstressed and in its most relaxed position. Any pressure difference across the drum results in some degree of stiffening, some loss of mobility and compliance. If there is a reduced pressure in the middle ear, the curve peak will occur when the pressure in the external ear canal is the same as that in the middle ear, and this pressure can be observed on the recording meter.

Different curves are obtained with different abnormalities of the middle ear. Probably the most common disorder in children is the one to which attention was drawn in the introduction, fluid in the middle ear. In this condition a completely different pattern is obtained. There are three main differences between the two curves. The height, the position of the point of maximum compliance, and the shape. These three factors can all be given quantitative values. The first is the compliance or the mobility of the middle ear system. The second is the pressure within the middle ear cavity. The third tells us how "peaky" the curve is, and this measure has been found to be most useful in determining the presence or absence of middle ear fluid.

VALIDATION STUDIES

For a sixth month period every child attending the E.N.T. department of one of the group hospitals was given a thorough examination of the ears, including impedance testing. If, on clinical grounds or as a result of the history or examination, there was suspicion of fluid being present in the middle ears, a paracentesis was carried out as soon as possible. (This is a puncture of the drum with the application of suction to withdraw any fluid present.) Fifty children were selected who on paracentesis were found to have had fluid in both ears. The curves of these children were analyzed for each of the three factors defining the curve, and a similar analysis was made for the curves of fifty children having perfectly normal middle ear function. These two groups of children were matched for age and sex. When the results were studied it was found possible to differentiate between normal ears and ears with fluid for each of the three parameters. Values were assigned to each of these factors such that if the observed measurement lay on one side of this value there was a high probability that the ear was normal, whereas if the measurement lay on the other side the probability was that fluid was present in the middle ear (5). To test these criteria, they were applied to the next 150 children seen in the audiology clinic prior to hospital examination. In over 90% of the cases the impedance test indications were proven correct by the surgeon. This accuracy compares most favorably with the conventional means of testing described previously.

STUDIES WITH SCHOOLCHILDREN

In February, 1968, an investigation was commenced into the middle ear function of children in infant and junior schools, employing the acoustic impedance bridge. I believe that in time the findings made will contribute towards the alleviation of conductive deafness as a social and educational handicap in children.

The aims of the investigation were to study the distribution of middle ear disorders, particularly middle ear fluid, among young schoolchildren and to try and determine the part played by certain factors in the development of fluid. It has been accepted for some time that this condition, called serous, secretive or exudative otitis media, occurs most commonly in "young" children. The actual rate of incidence and variation of occurence with age had not, however, been evaluated. This information is necessary to determine the magnitude of the problem and to judge whether the condition of middle ear fluid is one which undergoes spontaneous remission without detriment to the child's hearing, or whether treatment should be initiated as soon as any abnormality is detected or at some later stage in the development of the disorder.

Because atmospheric pollution had been suggested as a contributory factor in the development of conductive hearing disorders, the testing was carried out in two different localities, one a seaside town with a low level of atmospheric pollution and the other near the center of a large city where the level of pollution was relatively high. Two schools were chosen each having about five hundred children in the infant and junior departments. The ages ranged from four to eleven years. In the space of three months every child was tested, except one girl who was in hospital with tubercular meningitis. Testing took about five minutes per child on average, and in very few cases was there any sign of discomfort or resistance to the performance of the test. (This may be not unrelated to the fact that each child was "rewarded" with candy at the successful conclusion of the test.) In total 1053 children were tested.

Perhaps the most surprising finding when the results were analyzed was that there was no difference in the incidence of middle ear disorders between the two areas. It appears from this that atmospheric pollution does not play a very significant role in the development of middle ear disorders in children.

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(5) Brooks, D.N., 1968. Inter. Audiology. 8. 120.

Between the sexes there was a most noticeable difference. Middle ear fluid was nearly twice as common among boys at any age level, as among girls. This finding is supported by figures published by two American specialists showing that in the aural departments of their hospitals the ratio of boys to girls was about two to one (6,7). This pattern is also consistent with the general distribution of infant sickness and morbidity. A close study was made of 34 children (21 boys and 13 girls) in the admission class at one of the schools. In the first three months after their admission to the school the boys had, on average, 6½ days off through illness. The girls averaged only 2 days of sickness during the same period. Among the twenty-one boys there were seven that had clear signs of having persistent middle ear disorder. These seven had averaged 12½ days of sickness, whereas the other 14 boys had only averaged 3½ days of absence. There appears then to be a link between persistent middle ear malady and the length of time the child is off school on the grounds of sickness. This connection probably lies in the adenoids. The child who, after a cold or upper respiratory infection has inflammation and swelling of the adenoids, is a sick child. He is also, by virtue of the obstruction to the eutachian tube by the swollen adenoid tissue, prone to middle ear disorder. Research into this aspect of the problem is continuing.

The rate of occurence of middle ear fluid according to age produced a most interesting picture. At the upper end of the school, where the children were aged nine to eleven, the percentage of abnormalities was only about two or three per cent. With decreasing age the percentage rises so that at seven years of age five to six per cent of the children had clear signs of fluid in the middle ear. At six years of age this figure has risen to around ten per cent. At five it is nearer twenty per cent. This seems a very high proportion of the children, but confirmation that this figure was of the right order was obtained by a detailed study of the 29 children under five years of age. These children were all in their first term at school, having been admitted at Christmas just before the testing commenced in February. Twelve of these children gave positive indications of having fluid in the middle ear space. Each was examined by paracentesis within a few days, and in every case the test result was confirmed. Fluid was found in all twelve. Thus at four years of age, in the first term at school, over 40% of the children had middle ear fluid.

Emerging from this study is the fact that a high proportion of children in their first few months at school have upper respiratory infection, leading on to middle ear trouble. In many immunity is gradually developed

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(6) Davison, S.V., 1958. Laryngoscope. 69. 1228

(7) Davison, F.W., 1966. Ann. Otol. Rhinol. Largnol. 75. 735.

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and the attacks of inflammation diminish. In some children the repeated attacks of adenoiditis and tonsillitis are such that the general practitioner recommends the removal of these organs, and often the trouble ceases from the time the adenoids particularly are removed. Thus, after four or five years only a small number of children remain with poorly functioning middle ears. Because there is this decline with the passage of time, some authorities have suggested that no medical or surgical interference is either justified, or necessary. It is contended that nature and time will eliminate the trouble. This attitude does not take into account the educational handicap that may co-exist with middle ear abnormality. The child with fluid in the middle ear will have some reduction in hearing ability, the degree of which will depend to some extent on the viscosity of the fluid. With a thin watery fluid the loss may be only about 10 db. But often in longstanding cases the fluid becomes very thick, having a consistency rather like thick treacle or wax. In such cases the hearing loss may be as much as 50 db. - a quite severe handicap (8). Furthermore, if no treatment is carried out the hearing loss may become permanent, as shown by the two or three per cent of children at eleven years of age with depressed middle ear function. There may be other consequences of neglecting the initial condition. Cholesteatoma, a chronic infection of the middle ear and mastoid, is believed to be a result of prolonged vacuum and fluid in the middle ear. When present it may cause destruction of the whole of the middle ear and if not dealt with adequately it can give rise to intercranial complications.

CONCLUSIONS

Further research is needed to clarify the many problems that still remain. Nevertheless, it is believed that this method of examination of middle ear function meets the requirements set out in the introduction. Impedance testing is completely objective, that is, it requires no active participation of the subject. Tests have been performed on children less than one year old and in one instance the whole test was completed without the child's sleep being distrubed.

The assessment of the test results is simple in the majority of cases. Standards of normality have been established, and the degree of abnormality is determinable in numerical terms.

The test is easy to carry out. Although the time taken per child during this study was only five minutes, probably half this was taken in obtaining additional data, over and above the basic needs, for research purposes. Using a simplified test routine and an instrument specially designed for the purpose, the essential information could probably be obtained in about two minutes.

The test is reliable. In the clinical study an accuracy of better than 90% was achieved. Even with a simplified form of instrument and non-skilled, non-technical staff this accuracy is unlikely to fall below 75 - 80%. In many instances in our won studies, it has been possible to observe fluid in the middle ear with the impedance bridge before either the parent or doctor were aware of any abnormality, and before the child gave any indication of reduced hearing ability.

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(8) Goodhill, V. & Holcomb, A.L., 1958. Acta. Laryngol. 49. 38.

The test is acceptable to children. Many young children regarded the test with amusement. The boys particularly, when wearing the headset, imagined they were spacemen. When the young children heard there was a candy to be had at the end of the test, they responded with alacrity.

Although the impedance bridge is a relative newcomer to the field of auditory examination, it can fulfill a very valuable role in the early detection of conductive deafness. I believe a case can be made for the routine use of impedance measurement in young children as a screening procedure alongside, or in place of screening audiometry.

NAME: ______________________ EXAMINER: ______________________

DATE: ______________________

REASON FOR REFERRAL: ______________________

PRESENT PROBLEM (in parents' words when applicable): ______________________

FAMILY HISTORY

A. Father: Living: _____ Age: _____ Health Status: _________

B. Mother: Living: _____ Age: _____ Health Status: _________

C. Children: (list all pregnancies in order):

Name or Miscarriage	Sex	Age	Birth Weight	Laterality	Normal	Abnormalities or Other Comments
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

E. Diseases in lineals and collaterals:

1. Allergy
2. Cancer
3. Diabetes
4. Heart
5. Leukemia
6. Slow-in-school
7. Speech problem
8. Cerebral Palsy
9. Convulsions
10. Ment. retard.
11. Mongolism
12. Mental illness
13. Spina bifida
14. Arthritis
15. Other Neuro disorders
16. Cogenital malformations
17. Comment or other

F. Consanguinity (list details):

NARRATIVE SUMMARY FAMILY HISTORY: ______________________

MATERNAL HISTORY

a) Mother's health during preg. (check one): Well:____ Minor disorder:____ Major:____

Nausea and vomiting
Infectious diseases (Rubella, flu, mumps, etc.)
B.P. (hi or low, amt., when)
Urine Abnormality
Anemia
Bleeding
X-ray Rx. (when)
Nutrition (essen. foods, etc.)
Weight change (onset of pregnancy to delivery)
Medications
Other

b) Rh or ABO incompatibility

NARRATIVE SUMMARY OF MATERNAL HISTORY

BIRTH HISTORY - Hospital__________ Home__________

a) Delivery:

Gestation period: Term: Premy: Late: B.W.
Labor onset: Spontanieous Induced (type or indication:)
Medication during labor:
Labor: duration
Presentation:
Instruments:
Anesthetic:
Placenta or cord: Normal: Abnormal:
Other complications:

b) Condition of child during neonatal period:

"Blue Baby" Resuscitation Oxygen Incubator
Evidence of trauma
Convulsions
Jaundice (onset, degree, duration)
Age at time of discharge from Newborn Nursery:

NARRATIVE SUMMARY OF BIRTH AND NEONATAL HISTORY

DEVELOPMENTAL HISTORY

a) Handicap first noted: Describe

b) Age of accomplishments:

Rolled over
Sat alone
Crawled
Stood alone
Walked alone

Toilet training
Said words
Used sentences
Self feeding
Trike riding

GENERAL HISTORY

Infant feeding problems (chewing, swallowing, vomiting)

Constipation (duration, degree, Rx.)

Illnesses

Injuries

Convulsions

Surgery

Bracing

Immunizations

Education

Diet

Appetite

Medications

NARRATIVE SUMMARY OF DEVELOPMENTAL & GENERAL HISTORY

PHYSICAL EXAMINATION

Height ______ Weight ______ Head Circ. ______

General appearance

Head and face

Eyes (squint, nystagmus, fundi, etc.)

Ears

Nose

Mouth (teeth, tongue, movements, tonsils, etc.)

Chest

Abdomen

Genitals

Neuromuscular

a) Reflexes (indicate normal, hyperactive, diminished, or absent)

	RIGHT	LEFT	REMARKS
K.J.			
A.J.			
Clonus'			
Babinski			
Cremasterics			
Abdominals			
Biceps			
Triceps			
Periosteal			
Stretch reflex			

b) Sensory Disturbances

c) Contractures (c) or tightness (t)

Heel cords:	R	L	Shoulders:	R	L
Knees:	R	L	Elbows:	R	L
Hips- Adductors	R	L	Wrist Felxor	R	L
Int. Rotators	R	L	Pronators	R	L
Flexors	R	L	Fingers	R	L
	R	L	Others	R	L

Passive Hip rotation: internally-R ____ L ______ Externally-R ________ L ________

Resting supine posture -

Gait: Supported: Independent:

a) Rotation (lowers)
b) Equinus
c) Varus or valgus (feet, knees)
d) Scissoring
e) Flexion (knees, hips)
f) Genu recurvatum
g) Reciprocation (uppers & lowers)
h)

Coordination:

Cranial Nerves:

Other :

NARRATIVE SUMMARY OF PHYSICAL EXAMINATION

DIAGNOSIS (primary)
DIAGNOSIS (secondary)

ETIOLOGY. Firm: Proable: Suspected:

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Rationale for utilization of particular types of adaptive equipment and stimulation techniques

Prepared By

The Occupational and Physical Therapy
Department
Peoria Association of Retarded Citizens
United Cerebral Palsy of Northwestern Ill.

SCOOTER BOARD

Rationale for using -

1. Vestibular stimulation (refer to vestibular handout)
2. Muscle strengthening
3. Break up immature reflex
4. Upper and lower reciprocal motion
5. Develop motor planning

Suggested ways to use scooter boards -

1. On stomach, legs up off floor straight, pulling forward with arms.
2. On stomach, legs up pushing backwards with arms.
3. Sitting on scooter board like an Indian spinning self around and around.
4. Sitting and pushing self forward and around a maze.
5. Sitting and as in (4) but with eyes covered with paper bag.
6. On back pushing self along with feet, under table around a maze (watch for head to stay up).
7. Sitting on scooter board pulling self along a taut rope (watch for use of both hands).
8. Stretch rope between 2 points about one foot off the floor. Lie on back on scooter board and "ferry" self across the rope, pulling hand over hand.
9. Push off from wall with feet and "crash" into a tower of cartons.
10. Sit on scooter board and push self past barrel on box and then throw ball into it.

PURPOSE OF TONGUE WALKING
(using a tongue depressor)

The following desirable effects may be attained from tongue walking:

1. Improvement in swallowing thus leading to a decrease in drooling.
2. Decreases a bite reflex (child clamps down on a spoon and cannot let go).
3. Decreases tongue thrusting (tongue involuntarily comes out and/or pushes food out of mouth). When feeding, put the spoon into corner of mouth.
4. Desensitizes the tongue. The tip of the tongue is the most sensitive.
5. A push on the side of the tongue improves lateral motions of the tongue which may be absent or weak. Also, peanut butter or jelly in the corners of the mouth encourages lateral tongue movements.

SQUEEZE BOTTLES

The following are desirable effects that develop from use of squeeze bottles:

1. To improve sucking
2. To improve tongue strength
3. To improve head control (co-contraction)
4. To decrease drooling by stimulating swallowing and mouth closure
5. To improve general L oral motor control

TILT TABLE

1-75

Indications of child not tolerating present height:

1. rapid, shallow breathing
2. increased pulse - should not be over 130/minute
3. clammy skin
4. pale, grayish skin color
5. lethargic

If child passes out:

1. lower table to horizontal position
2. raise child's arms or legs
3. put cold towel behind his neck
4. call nurse

Tilt table procedure:

1. Begin each child at 30° for 15 minutes daily.
2. Increase 10° each week if child has tolerated the previous degree
   1st week - 30°
   2nd week - 40°
   3rd week - 50° etc.
3. Increase until maximum height is 75°.
   *If child has a dislocated hip, maximum height is 45°.
4. Once child has attained 75° or 45°, continue with that height.
5. If child has been absent, his previous maximum height may need to be lowered until he readjusts to the tilt table.

*Only those children with specific tilt table orders are to go on the tilt table.

TILTED BEDS

The foot of the bed is raised approximately 4-6 inches.

The following are desirable effects attained from tilting the foot of a bed:

1. Drainage from lungs of mucus secretions to where the secretions can be swallowed or coughed out.

2. Improvement in extensor tone. The children placed in this position do not have adequate head and trunk stability. In this position the children must contract the muscles of the neck as well as the back in order to view surroundings.

THE PURPOSE OF POSITIVE SUPPORTING SHOES
(Cut-off Shoes)

The positive supporting reaction is set off by any stimulation to the ball of the foot. If the reaction exists in a child, his feet will point downward and his knees and hips will straighten when the balls of his feet are stimulated. However, the response depends on the strength of the reaction. It may exhibit itself only by the child walking on his toes with knees straight or by walking wide-based and unsteady. The positive supporting reaction is normal in a child from 0-6 months of age. After 6 months, the reaction should become inhibited. In a physically handicapped child, the reaction may be prolonged or excessively strong.

One avenue of treatment for a positive supporting reaction includes activities while wearing cut-off shoes. The cut-off shoes remove stimulation from the balls of the feet. They, also, encourage weight in the heels which is necessary for a steadier gait pattern. Cut-off shoes will encourage lifting the toes upward. This, too, is necessary for ambulation.

TONIC LABRYNTHINE BOARD
(with toys placed within arms reach)

The following are desirable effects to be attained from use of a tonic labrynthine board:

1. Improves extensor tone including elbows and wrists.
2. Encourages use of arms - many of the children keep their elbows bent (flexed). In this position his arms are facilitated to straighten (extend), wrists can raise and hands can be used better.
3. Drainage from lungs of mucous secretions.
4. Hips and knees are free to straighten (extend).
5. Prevent tightness at hips. (Hip flexor tightness).

VESTIBULAR STIMULATION

(Rolling in barrel, rolling, swinging in hammock, upside down)

1. One of the most powerful tools in remedying difficulties in sensory organization of body.

2. Passive V.S. is most effectively given by swinging or spinning a child while he is lying or seated in a net hammock. Rolling in barrel, swinging in air, upside down, on spin board, etc. are also used. A child who is afraid at first should be left to swing (roll, etc.) himself (active V.S.).

3. Many children show no effects, show no or diminished mystagmus of eyes (rapid horizontal movement of eyes), and a tendency to not become dizzy.

4. Slow rocking can also be given passively to a child lying on stomach over a ball.

5. Spinning in a net produces a different type of sensory input from swinging back and forth in it. Also spinning upside down, lying on stomach on back or on ones side will produce different effects.

6. Children with learning disorders vary greatly in their tolerance to V.S. Some are afraid and their fear should be respected. They are being realistic, for they cannot integrate the sensory input and respond to it in an adaptive manner (i.e., to crawl into a barrel lying on its side is to surrender oneself to an unstable world that knocks one about at its will).

7. Children like ones above need a slow, safe non-threatening approach to V.S.

8. Children who show little response to V.S. should start treatment with as much rapid spinning as they desire.

9. This has been offered to children with abnormal behavioral and schizoid-like features and they have asked for more and more and faster and faster V.S.

Taken from A. Jean Ayres, Ph.D.
"Sensory Integration and Learning Disorders"
Los Angeles, California, Western Psychological Services,
1974 --- Prepared by OT-PT Department

WHY RUBBING (TACTILE STIMULATION)

1. Rubbing contributes to neurological sensory integration.

2. Provides primal source of input into the main and most powerful integrating (organizing) systems of the body.

3. A child can be "energized" or hyperexcitability reduced.

4. Acts upon muscle toning.

5. Because of preparatory influence upon body, a session is often initiated with rubbing.

6. Use dry wash cloth or other type of cloth or brush child likes. Sometimes silk, velvet or your own hand is preferred.

7. Touching himself may be less threatening.

8. Rubbing before applying tactile stimulation often appears to reduce tactile defensiveness.

9. The child's response is considered the best indication of how stimuli is being received by body: (general rule). That which is enjoyable is being integrated (organized).

10. The skin surface to be rubbed can be determined either by availability or by child's choice.

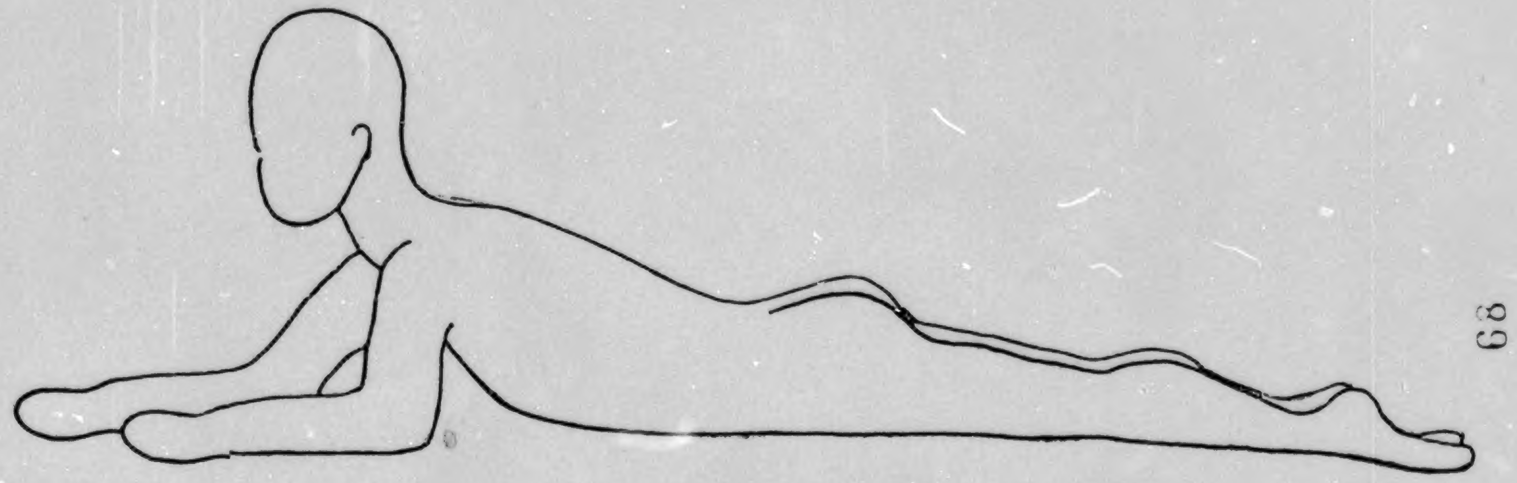
11. Back of hands and forearms are usually least defensive. The tummy, face, and feet are often the less accepting.

12. Stimulation is estimated roughly at lasting one-half hour.

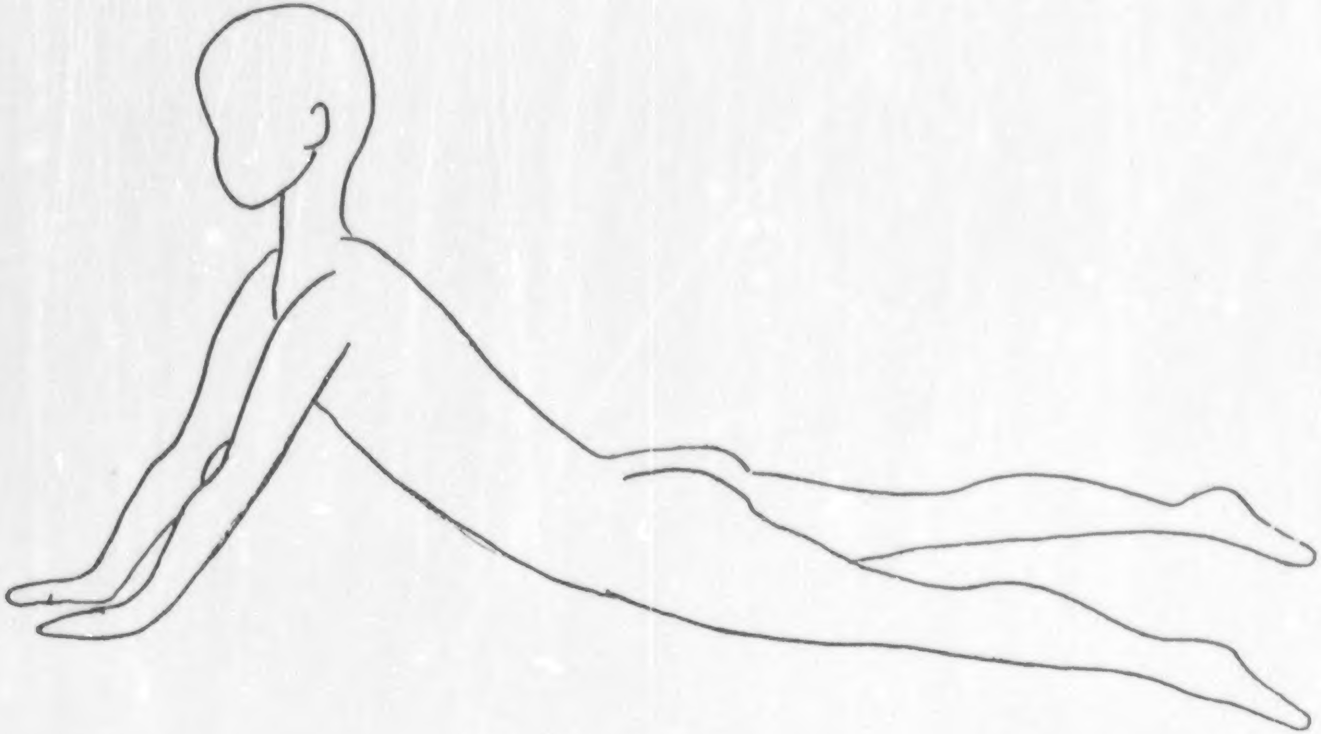
13. Sometimes with treatment over several months many children reach a point where they no longer want tactile stimulation but after a few weeks without it, they ask for it periodically.

14. Tactile stimulation as a therapeutic process may appear to the naive observer to be a very simple procedure, unrelated to the problems at hand.

All taken from: A. Jean Ayres, Ph.D.
"Sensory Integration and Learning Disorders"
Los Angeles, California
Western Psychological Services, 1974



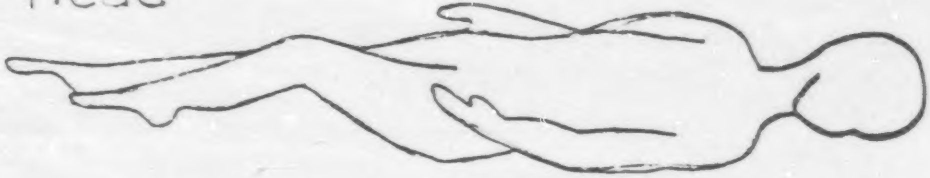
Prone on elbows



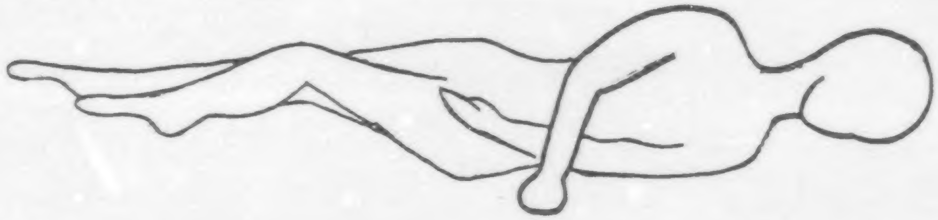
Pushing up on extended arms

Segmented Rolling

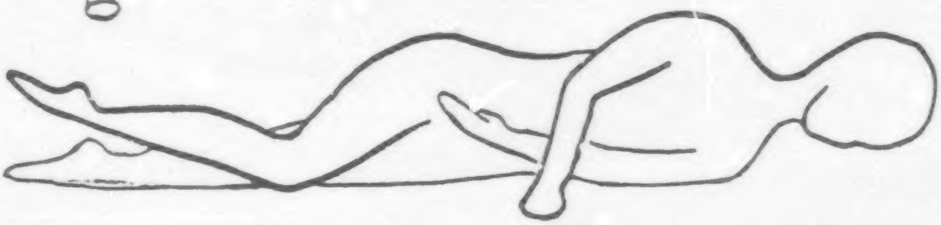
1 head



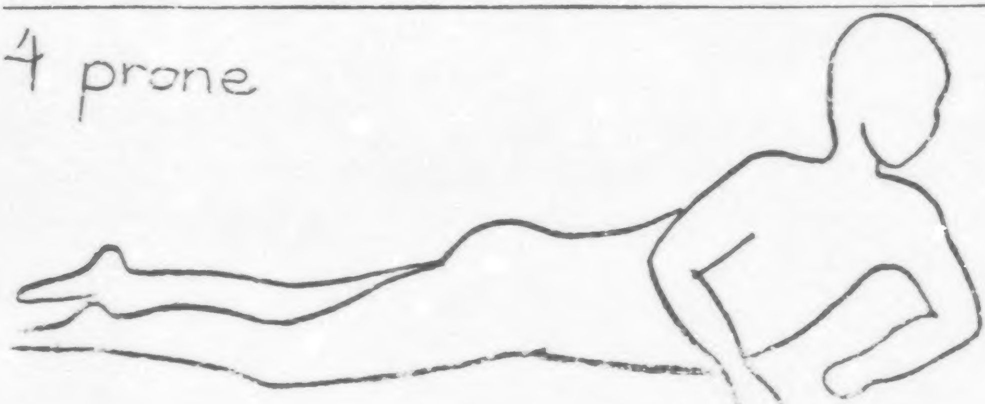
2 arm



3 leg

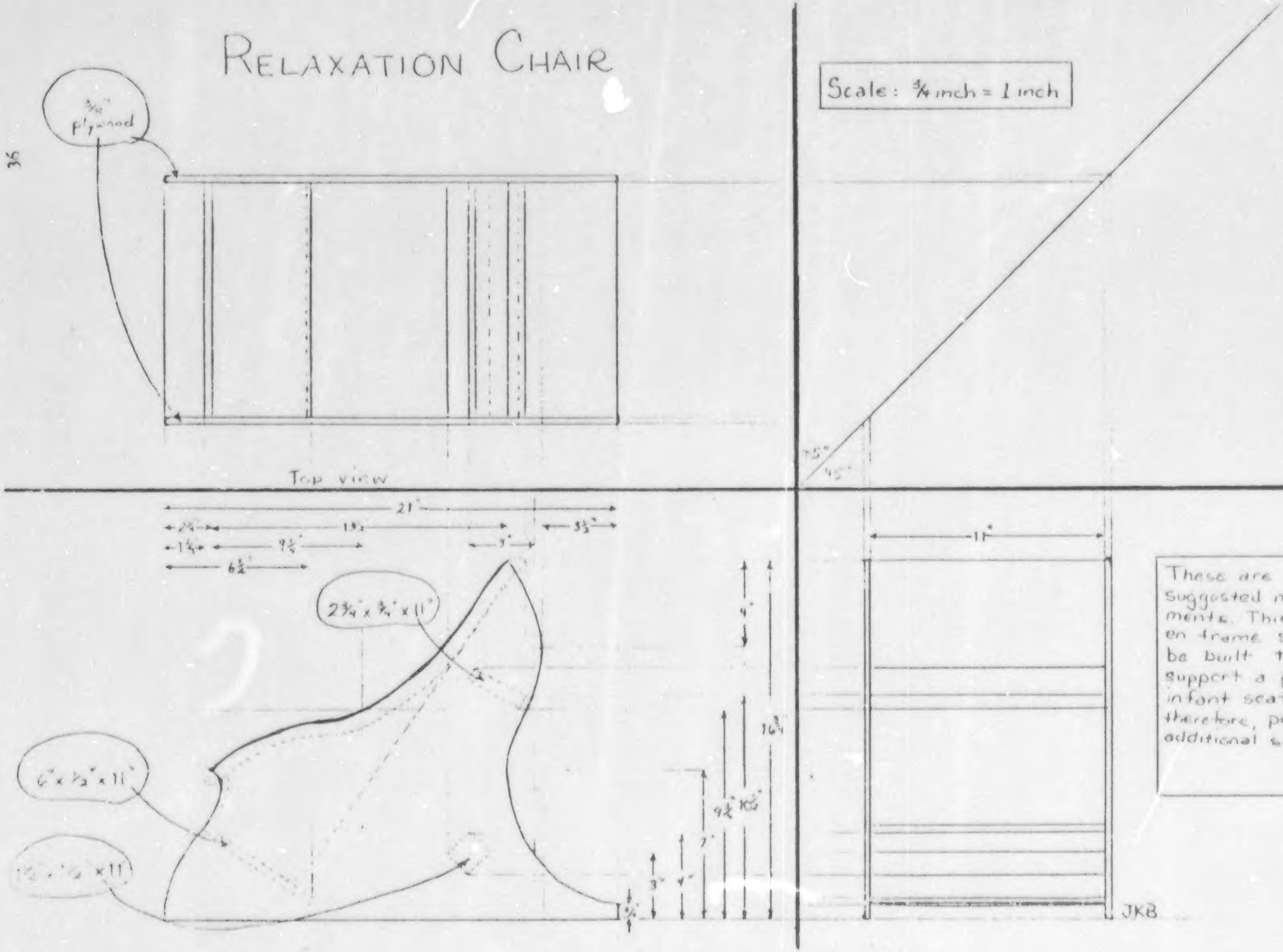


4 prone



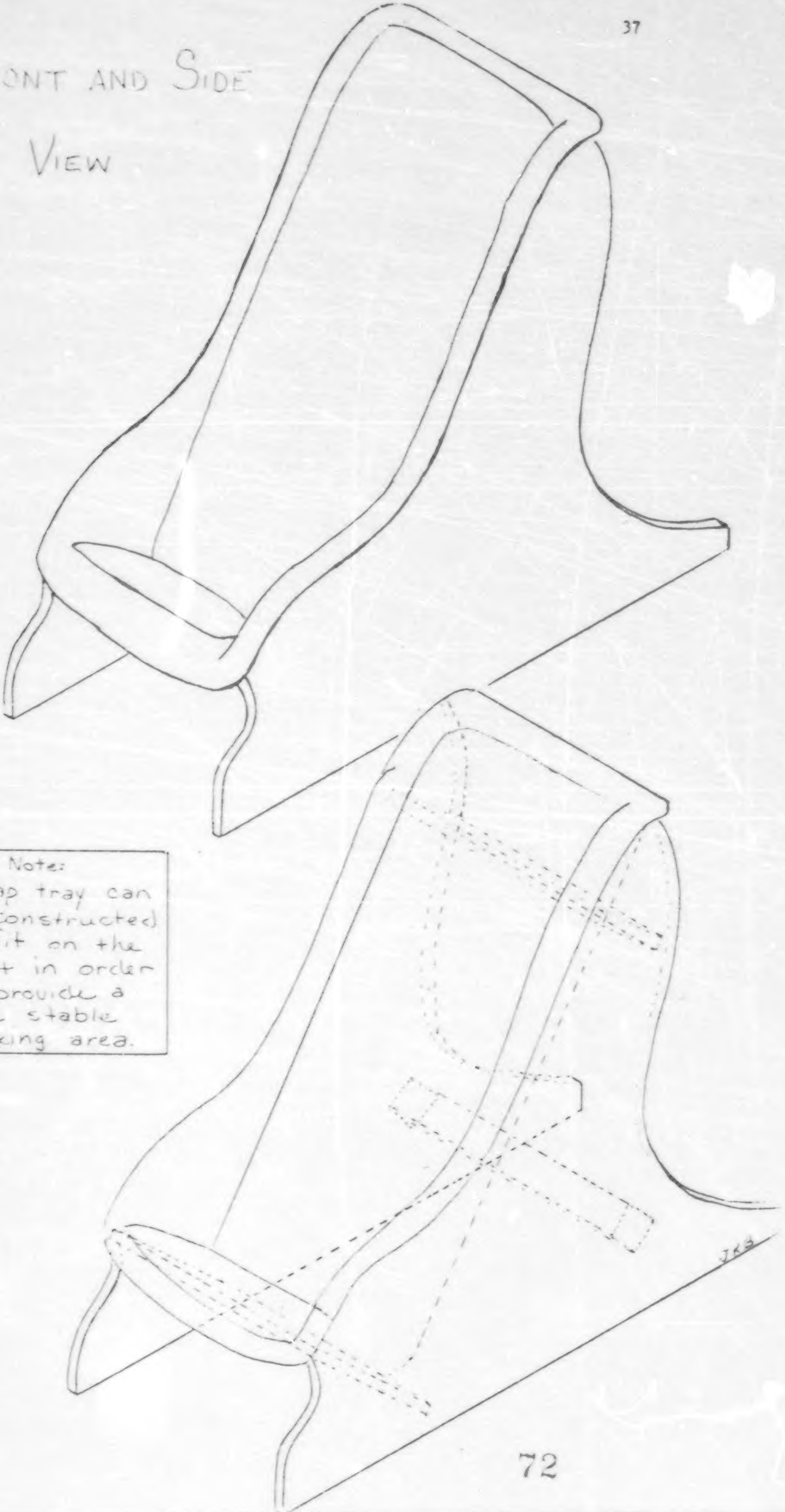
RELAXATION CHAIR

Scale: ¾ inch = 1 inch


⅜" Plywood
Top view
21"
2¼"
13½"
3½"
1¾"
9¼"
3"
6½"
2¾" x ¾" x 11"
6" x ½" x 11"
1½" x ½" x 11"
¾"
3"
4"
7"
9¼"
10½"
16¾"
4"
11"
75°
45°
JKB

These are only suggested measurements. This wooden frame should be built to support a plastic infant seat, and, therefore, provide additional support.

FRONT AND SIDE VIEW



Note:
A lap tray can be constructed to fit on the front in order to provide a more stable working area.

The Homebound Program for Developmental Needs is used in conjunction with the Functional Profile. It was developed for use with the Peoria 0-3 Project. In order to better understand the Child Development Worker's role in this program a brief description of the project follows.

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HOMEBOUND PROGRAM AND THE CHILD DEVELOPMENT WORKER

I. Rationale

A. To Aid: Children with special needs in developing their maximum potential by use of an individualized home program.

B. To Guide: Parents in understanding the child's developmental needs.

C. To Guide: In developing parental skills, thereby, strengthening the family as a unit.

II. Program Procedure

A. Evaluation

1. The Child Development Worker administers the "Functional Profile" in the home or office. (See Appendix I for example).

2. Teaching aids, educational toys, books, and adaptive devices are provided for use by the family in teaching structured activities.

3. Informative reading materials are available without charge to the parents.

4. The Child Development Worker schedules the child for appointments with the following specialists for an in-depth evaluation:

    a. Speech and Language Therapist

    b. Denver Developmental Screening Specialist

    c. Medical Clinic (Medical Specialist)

    d. Psychologist (for children over 2 years of age)

    e. Physical Therapist

    f. Occupational Therapist

    g. Outside Consultants not available within the agency

        1) Neurologist

        2) Otologist

        3) Opthamologist

        4) Etc.

5. All results of evaluations are compiled on the evaluation summary sheet which is then returned to the Child Development Worker who makes sure all information is complete. (See Appendix II for example).

6. The Child Development Worker arranges a staffing with all necessary specialists on staff who are directly involved in the case. Program recommendations are discussed and finalized at this time.

7. After the in-depth staffing is completed the Child Development Worker places recommendations in the child's file.

8. An appointment is scheduled with the parents by the social worker at which time the social worker and the Child Development worker discuss with the parents the findings and recommendations of the child's evaluation.

III. Homebound

A. Observational Guide Lines (See Appendix III for a brief description).

B. When indicated a Child Development Worker initiates a home visit program in which individualized activities or lesson plans are delivered on a basic schedule into the home. (See Appendix IV for example).

   1. The Child Development Worker may improvise her own lesson plans or has them provided from other specialty areas such as speech and language occupational therapy, physical therapy, etc.

   2. The plan is introduced to the parents and methods of charting and recording are explained.

C. In most instances the family is visited once a week, so new lesson plans are taken into the home and the finished ones are picked up to be charted and filed for further use.

D. Children are re-evaluated yearly unless otherwise indicated and visits are continued until the child is either placed in another appropriate program or the case is closed.

IV. Scheduling Time

A Child Development Worker in the homebound program can handle a caseload of 10 - 15 children.

The workers make 35 - 40 home visits a month, spending 3½ days a week on visits. The remainder of the 5 day week is spent in the office working on lesson plans, data keeping, staffing children, and evaluating new children referred for service.

APPENDIX III

The observational guidelines for family interaction is a parent management skills check list used by the Child Development Worker to evaluate the families interaction with their child. It enables the worker to target areas of development that need stimulation. The profile assesses skills in the areas of social, language, motor, self care, and toileting. The information provided by these guidelines was designed to be used only by staff working directly with the family. It is not intended to be sent to outside agencies or as part of a child's permanent record.

OBSERVATIONAL GUIDELINES FOR FAMILY INTERACTION
(Revised Edition of Parent Management Skills)

These guidelines were developed in order to:

1. Help families provide appropriate stimulation for their children and
2. Provide an objective method for determining existing stimulation techniques being used by the family.

In administering this profile it would be beneficial to:

1. Read and become familiar with guidelines before observing a family.
2. Keep objectives in mind when visiting a family.
3. Obtain as much information as possible by observation.
4. Obtain items not readily observable through informal discussions.
5. Visit the home at least twice to assure that your initial observations were in fact reliable.
6. Complete all items outside of the home, without the parents being present.

This set of guidelines was designed to be used by staff who are working directly with the family. Information which is obtained is not intended for dissemination to other agencies or for entry in child's permanent file.

OBSERVATIONAL GUIDELINES FOR FAMILY INTERACTION
(Revised Edition of Parent Management Skills)
(Page 2)

Date Completed ___________

Child's Name _________________ B/D _____________

Dates of Visits __________________ Starting Date ___________

Review Date ___________

Source of Information ______________________________________

SOCIAL

1. Is child interacted with warmly both through physical contact and verbalization?
2. Are positive rather than negative behaviors of the child reinforced, particularly in his presence?
3. Are other adults and children allowed to give child care and to play with him?
4. Are behavior problems handled consistently?
5. Is child exposed to other environments outside home setting, i.e., shopping, visiting friends, restaurants, church?

LANGUAGE

1. Is child provided with pleasant verbal stimulation by verbal and nonverbal imitation, labeling objects and sounds, allowing child to express himself?
2. Is an attempt made to get eye contact and stoop to child's eye level when speaking to him?
3. Is child given opportunity to verbalize, rather than point, to express needs?
4. Is child's level of communication accepted? Adult may repeat child's response correctly but should not pressure him for it.

MOTOR

1. Is there an awareness of simple developmental stages of motor development? Gross Motor: rolling over, holding head up, sitting, creeping, pulling up, standing, etc. Fine motor palmer grasp, pincer grasp, eye-hand coordination, etc.

2. Is proper equipment and appropriate play material provided for child's age level and/or handicaps?

3. Is some time spent each day in active and quiet play activities?

SELF CARE

Eating

1. Is there an understanding of the importance of providing a pleasant atmosphere at mealtime?

2. Are appropriate foods and correct utensils provided for child's age and development?

3. Is child allowed to progress through developmental stages of self feeding--from finger feeding to use of spoon, cup, fork, tolerating messes, etc.

4. Is supervision provided at mealtime and praise given to child for eating accomplishments, i.e., neatness, manners?

Toileting

1. Is there an awareness of individual child's readiness and physical capabilities for toilet training?

2. Are proper facilities provided? Does child remain on toilet for unreasonable lengths of time? Is he placed on toilet in accordance with his schedule or routine?

Summary:

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APPENDIX I

FUNCTIONAL PROFILE

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PEORIA AREA RETARDED CITIZENS
AND
UNITED CEREBRAL PALSY

OBSERVATIONAL GUIDELINES FOR USE OF THE FUNCTIONAL PROFILE

I. What is the Functional Profile?

A checklist of developmental skills and social traits that normal infants and young children usually acquire or can perform at certain ages. The profile does not result in a "score" but rather a functioning level. It was compiled from selected materials by authorities recognized in the field of child development.

II. Why should a Functional Profile be completed on a child?

A. To determine an approximate level of functioning.
B. To aid in planning a program suited to the child's individual needs that will enhance his developmental strengths and improve his weaknesses.

III. Who should complete a Functional Profile on a child?

Persons who have some basic knowledge and experience with the normal growth and development of infants and young children and who are involved in program planning for the child.

IV. Where and how should a person complete a Functional Profile?

Where

A. Preferably in the home setting or a familiar environment.
B. If given in an agency setting, a child-oriented environment could be created by:
   1. Child size furniture
   2. Good assortment of toys
   3. Adequate space
   4. Carpet or rug

How (See Appendix I for materials needed to complete Functional Profile)

A. Observer should establish rapport with child before beginning the Functional Profile.
B. Generally begins with gross motor area as this often is most easily observable.
   --Functioning level obtained in the gross motor area has been found to be a good indicator for a starting point on other sections of the Functional Profile.

A. Begin tasks at Chronological Age.
  1. If all items are not successfully completed, drop back two age levels and attempt completion at that level.
    a. Continue dropping back in levels of two until child successfully completes all items in a level. This establishes the basal.
    b. Continue back at least two subsequent levels to identify gaps in development.
      1) If items are completed at Chronological Age, proceed upward item by item until all items in a given level are failed. This level would be considered the ceiling.
      --Continue at least two levels beyond to determine if emerging skills are present.
      2) For example see Appendix IIa and IIb.

B. Those behaviors not observable should be obtained by talking with the parent or other informant well acquainted with the child.
  --Some parents may over or under estimate child's functioning level.

Establishing Functional Level and Interpretation

A. Methods for recording: Enter date in appropriate column.
  1. Yes/date: to be recorded only if child's performance of the task or a behavior is typical.
  2. No/Date: Behavior is not evident.
  3. Enter ? in No/Date column if skill or behavior is not consistent. The ? is considered a failure, but indicates a good starting point for planning activities.
  4. Added notations about a child's behavior or performance should be included in the completion of the profile.
  --Especially if performance is felt to deviate from the norm.
  5. Each time functioning level is re-evaluated, the child's original form is used.

B. Interpretation
  1. The child is said to be functioning at the highest level at which one more than half of the items are passed.

V. Graph

A. Upon completion of the Functional Profile, functioning levels are plotted on the graph.

B. Key for plotting graph:
  a. ____first completed functional
  b. ....second completed functional
  c. ._._third completed functional

C. For example see Appendix IIIa and IIIb.

APPENDIX I

MATERIALS FOR COMPLETION OF FUNCTIONAL PROFILE*

I. Social

No materials needed.

II. Cognitive, Linguistic, and Verbal

1 bell or noise maker
1 set plastic keys
1 Fisher Price music box radio
1 common object picture book
1 small doll
1 hand mirror
1 set action pictures
1 dozen small wooden color cubes
1 dozen small plastic objects or pictures for categorizing
2 small boxes with lids or cans for shaking objects

III. Gross Motor

4 one piece puzzles, circle, square, triangle, rectangle, or oval
1 egg beater
1 small ball 3" diameter

IV. Fine Motor

Several primary size pencils
2 dozen small various shape blocks
1 box large crayons and paper
2 peg boards large clothespin pegs
1 pair 4" blunt scissors
1 package large beads and stringers
1 training board or book for buttons, tying, etc.
1 set Fisher Price stacking rings

V. Eating

No materials needed.

VI. Toileting

No materials needed.

*A 17" X 12" carrying case is recommended for storage and transportation of materials.

APPENDIX IIa

EXPLANATION: Chronological age at date of evaluation was 20 mos. Emerging skills were noted in the 10-13 mos. areas but task performance was consistent only at the 9 mo. level. Because of this, it was assumed that gross motor functioning level was nine mos.

Child's Name____________________________ Child Development Worker__________________

GROSS MOTOR

	Age Level	No	Developmental Tasks	No/Date	Yes/Date
8-20-74 CA: 20mos.	8 mos	1	Creeping or belly crawling-abdomen is dragged over supporting surface using mainly shoulders & elbows - legs remain extended		
		2	Independent sitting balance		
		3	Bridging movements-when lying on back, bends knees-puts feet on support-lifts hips to make bridge		
		4	Forward & backward creeping or crawling abdomen raised weight supported		
Functional Level 9 mos.	9 mos	1	Pulls to standing position on 4 extremities		8/20/73
		2	When hands supported will maintain standing position for at least 5 minutes		8/20/73
		3	Can make stepping movements		8/20/73
		4	Can sit alone & change positions w/out falling		8/20/73
	10-12 mos.	1	Begins cruising-sidestepping around furniture	?	
		2	Walks w/one or both hands held		8/20/73
		3	Is able to stand alone for at least 1 min.	?	
	13 mos	1	Stands alone with feet apart	?	
		2	Bends and regains balance	8/20/73	
		3	Can crawl up one step	8/20/73	8/20/74
	14-15 mos.	1	Can maintain kneeling position at least 1 min	8/20/73	8/20/74
		2	Walks independently but may still fall occasionally	8/20/73	
		3	Can crawl up several steps	8/20/73	
	16-17 mos.	1	Runs flatfooted - eyes fixed on ground		
		2	Pushes toys both standing erect & bending		
	18-20 mos.	1	Walks up stairs - one hand held		
		2	Throws ball overhand		
		3	Kicks ball forward after demonstration		
		4	Backs into small chair to sit - climbs forward into adult chair then turns to sit		
	21-23 mos.	1	Walks downstairs - one hand held		
		2	Jumps in place		

APPENDIX IIb

EXPLANATION: Chronological age at date of evaluation was 16 mo. Task performance was consistent only at the 6 mos. level. Because all skills were not acquired below this due to the presence of hydrocephalus, gross motor functioning level was assumed to be 5 mo.

Child's Name__________________________ Child Development Worker____________

GROSS MOTOR

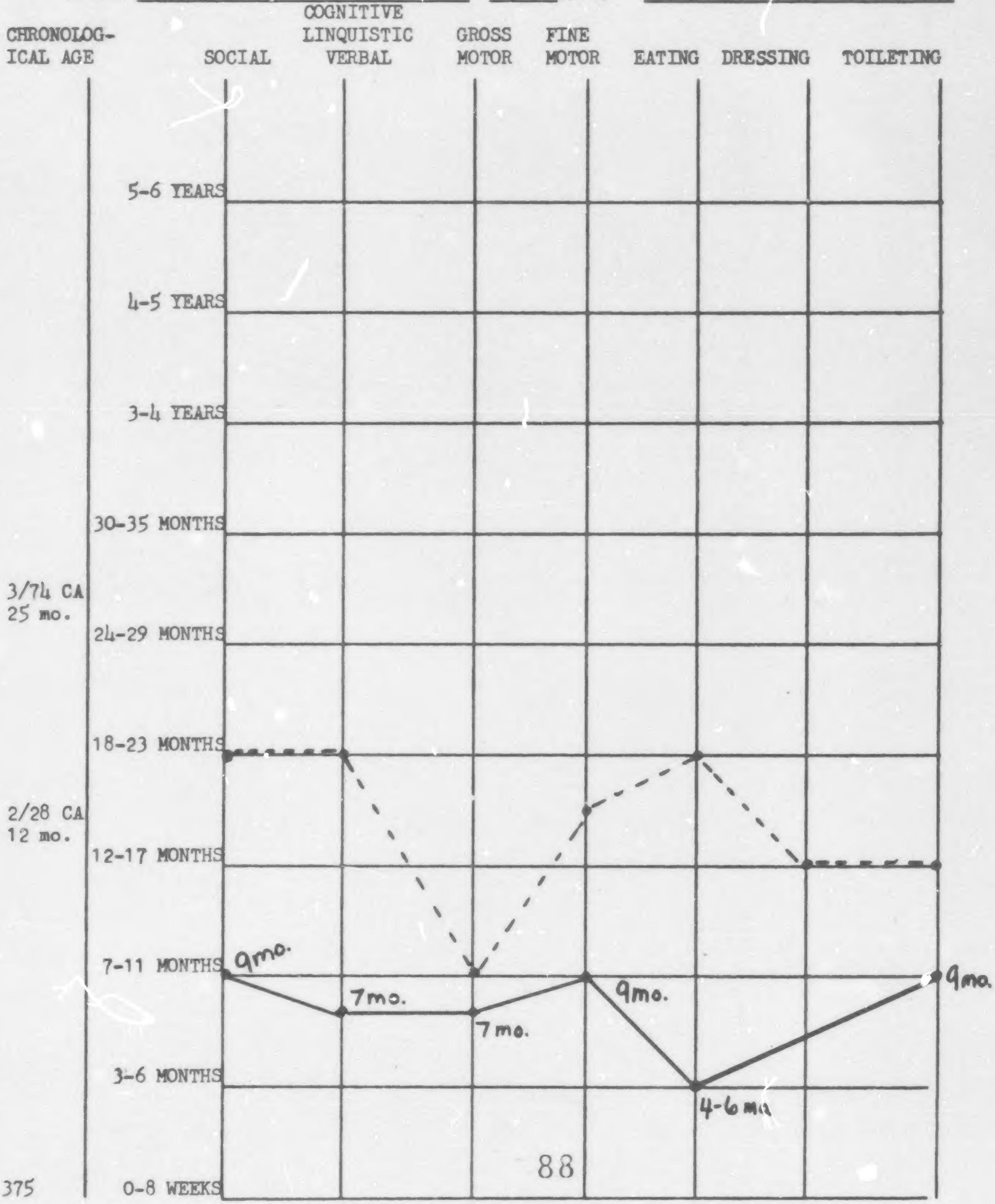
CA: 16mo

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
1 mo.	1	Rooting & sucking reflex		
	2	Lifts head slightly from prone position & maintains position for 5 seconds		
	3	Ventral suspension from prone - head droops		
	4	Straightens leg when pressure is applied to bottom of feet		
	5	Fencing position w/head & arms (assymetrical tonic reflex should disappear by at least 6 mos.)		
	6	Head lags, falls back when pulled to sit		
	7	When placed in sitting position-head slumps forward on chest -back is evenly rounded		
	8	On flat surface head rotates-baby makes small crawling movements-legs in fetal position		
2 mos.	1	Lying on stomach - baby can lift head	?	
	2	Reflexive reciprocal kicking		7/73
	3	Head erect & bobbing when in sitting position	7/73	
3 mos.	1	Rolls from side to side, left & right		7/73
	2	When lying on stomach, rests on forearms raising head and chest	7/73	
4 mos	1	Hands are usually near face & chest - uses both hands in unison		7/73
	2	Ventral suspension from prone - baby holds head up	7/73	
	3	Props body up on forearms-tends to fall on side-just on verge of rolling to supine	7/73	
	4	Legs are stretched out		
5 mos.	1	Lifts head from supine		7/73
	2	When supported sitting baby's back is sturdy head erect but set forward & steady	7/73	
6 mos	1	Rolls to stomach		7/73
	2	Lifts legs high - holds them out straight		7/73
	3	Grips object w/whole hand voluntarily Palmar grasp		7/73
7 mos.	1	Brings feet to mouth	7/73	
	2	Sits on hard surface-trunk erect w/minimal support-adult's hands on hips-head & trunk aligned	7/73	
	3	When held in standing position child bounces	7/73	

APPENDIX IIIa
CHILD'S FUNCTIONAL EVALUATIONS FOR THE DEVELOPMENTAL 0-3 PROJECT

Child's Name
Birth Date 2-13-72
Parent's Name
Address

Observations	Date	Observers Name
(1st)	2-28-73	
(2nd)	3-20-74	
(3rd)		



APPENDIX IIIb
CHILD'S FUNCTIONAL EVALUATIONS FOR THE DEVELOPMENTAL 0-3 PROJECT

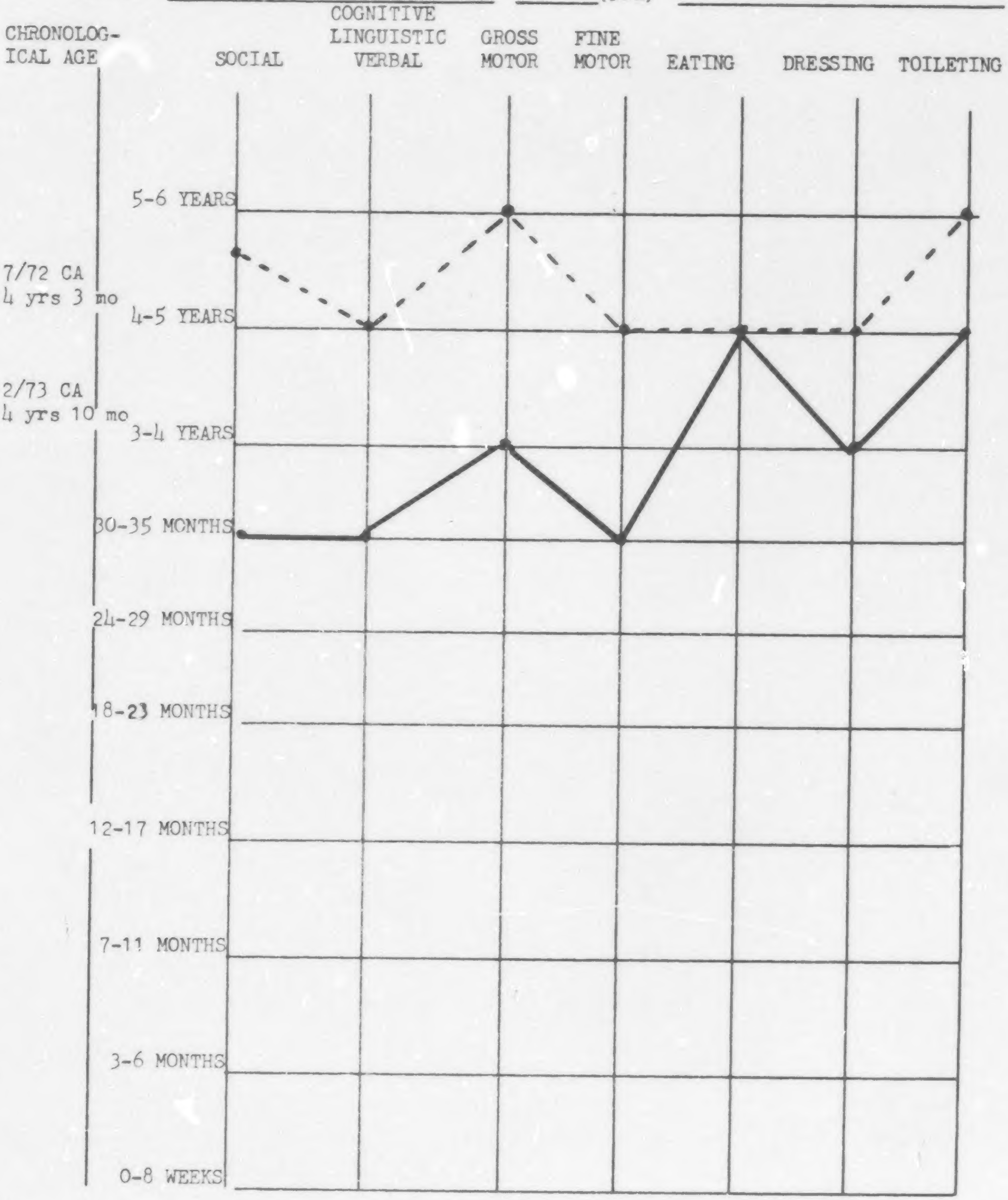
Child's Name ________

Birth Date 4-24-68

Parents' Name ________

Address ________

Observations	Date	Observers Name
(1st)	7-10-72	
(2nd)	2-2-73	
(3rd)		



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Allied Agencies Center - 320 East Armstrong Ave. - Peoria, Illinois 61603

Child's Name____________________Child Development Worker____________________

SOCIAL

Age Level	NO.	Developmental Tasks	No/Date	Yes/Date
1 mo.	1	Sometimes stops all activity to stare at surroundings		
	2	Ceases crying when picked up, cuddled or fed		
2 mos.	1	When spoken to regards a person's face		
	2	Eyes follow a moving person or object		
	3	Smiles		
	4	Recognizes mother		
3 mos.	1	Attempts some vocalization when talked to		
	2	Looks at own hands		
	3	Enjoys people w/out distinguishing strangers from familiars		
	4	Pulls at clothes		
4 mos.	1	Pulls back when adult playfully tries to take toy		
	2	Sits propped 10-15 mins.		
	3	Hand play - mutual fingering		
5 mos	1	Smiles at mirror image		
	2	Turns head toward sound of talking or singing		
6 mos	1	Smiles and vocalizes at mirror image		
	2	Sits propped for 30 mins.		
7 mos	1	May sometimes be frightened of strangers		
	2	Likes pat-a-cake and peek-a-boo games		
	3	Reaches and pats mirror image		
8 mos.	1	Bites and chews toys in play		
	2	Tries persistently to get toys out of reach		
9 mos.	1	May object loudly to disappearance of toy or person		
10 mos.	1	Waves bye-bye and pat-a-cakes		

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Child's Name________________________Child Development Worker________________________

SOCIAL

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
11mos.	1	Offers toy to person but does not release		
	2	Gives affection hugs, pats --to familiars		
12 mos	1	Likes to be within sight and hearing of adult		
	2	Releases toys to adult on request and sometimes spontaneously		
13 mos.	1	Chasing and hiding games are great favorites		
	2	Puts toys to mirror		
14 mo .	1	Indicates wants by pointing and vocalizing		
15 mos.	1	Often indicates refusal by bodily protest		
	2	Throws toys in play or rejection		
	3	Is curious, active, needs to be restricted to places where he can't get into trouble		
	4	Dependent on adults reassuring presence		
16 mos.	1	Shows or offers toys to adult		
17 mos.	1	Is easily diverted and entertained		
18-23mos	1	Explores environment energetically		
	2	Briefly imitates simple actions-i.e., reading book, kissing, doll, etc.		
	3	Alternates between clinging and resistance w/familiar adults-may have sit down temper tantrums		
	4	Often does the opposite of what is asked of him		
	5	Understands what belongs to different people i.e., Mom's or Dad's shoes, siblings toy		
	6	Plays near other children but not w/them - no exchange of toys.		
24-29mos.	1	Has pride in own clothes-especially shoes and socks		
	2	w/adult help begins to exchange toys with other children		
	3	Follows mother around the house and copies domestic activities		
	4	Has strong feeling of ownership & constantly refrains me or mine		
	5	Throws tantrums when thwarted & is no longer easily distracted		

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Child's Name____________________Child Development Worker____________________

SOCIAL

Age Level	No.	Developmental Tasks	No/Date	Yes Date
30-35 mos.	1	Independent dramatic play-putting dolls to bed, feeding them, driving cars, etc.		
	2	Snatches & grabs toys from other children		
	3	Watches other children at play - may join in w/out adult help		
	4	Enjoys using same playthings as child next to him		
	5	Likes routine in daily activities and clings to familiar toys and clothing		
3-4 yrs.	1	Joins in play w/other children w/out adult help		
	2	Understands waiting for or taking a turn		
	3	Shows affection for babies, younger siblings		
	4	Helps at household tasks (picking up toys-dusting-bringing items on request)		
	5	Performs for others (appropriately - i.e., reciting a nursery rhyme, etc.)		
	6	Likes to play with 2 or 3 children - may have a favorite friend		
	7	Separates easily from mother		
4-5 yrs.	1	Is competitive in games		
	2	Tends to go out of prescribed bounds		
	3	Talks back when does not get own way		
	4	Prefers group play with other children		
	5	Bosses and criticizes		
	6	Shows off - calls attention to self		
5-6 yrs.	1	Continues domestic, dramatic play from day to day		
	2	Plans and builds constructively		
	3	Chooses own friends		
	4	Understands needs for rules and fair play		
	5	Comforts playmates in distress		
	6	Enjoys dressing up in adult clothes		

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Child's Name____________________ Child Development Worker____________________

COGNITIVE, LINGUISTIC & VERBAL

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
0-1 mo.	1	Little or no facial expression		
	2	Loud sound causes startle reaction - arms extend, body stiffens		
	3	Soothed by soft intimate talking or singing		
	4	Vocalization-crying small throaty noises		
2 mos.	1	Makes sucking sounds		
	2	When spoken to looks at person's face expression is alert		
	3	Smiles in response to being talked to		
	4	Eyes follow a moving person		
	5	Begins to make some single vowel sounds (ah, eh, uh)		
	6	Sometimes ceases all activity to stare when sharp sounds are made - ringing bell		
3 mos.	1	Searches for sound with eyes		
	2	When lying on back, motions of arms & legs increase at the sight of bright colored object		
	3	Adult face still holds interest longer than anything else		
	4	Can coo, chuckle, or gurgle		
4 mos.	1	Responds to tone of voice - smiles or cries		
	2	Laughs aloud when lightly tickled or talked to		
5-6 mos.	1	Eyes locate source of sound		
	2	Entertains self (vocalizing) when alone instead of crying		
	3	Begins babbling spontaneously to person's face		
7mos.	1	Language includes cooing, squealing & combined vowel sounds (m-m-mum) when crying		
	2	Pats & smiles at mirror image		
	3	Inspects objects with eyes and hands		
	4	Shows recognition of name-responds w/eye contact, smile or turns head toward person calling name		
8 mos.	1	Can imitate physical movements-peek-a-boo, hand clapping, etc.		
	2	Vocalizes & can imitate single syllables (da ba ka)		

Child's Name____________________ Child Development Worker________________________

COGNITIVE, LINQUISTIC & VERBAL

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
9-11 mos.	1	Shakes head no-no		
	2	Watches & attempts to imitate demonstration in use of toy		
	3	Has two or three words which he uses w/meaning (ma, ma; da, da; bye, bye, etc.		
	4	Expressive jargon appears-child gives adult impression that vocalizations have meaning		
12 mos.	1	Obeys simple commands accompanied by gesture such as no, no; sit down, etc.		
	2	Responds to music w/some vocalization		
13-15 mos.	1	Has speaking vocabulary of 4 or more words-names of objects familiar to him in his daily environment		
	2	Can point to nose, eyes, ears, mouth or hair (3 out of 5) upon request		
16-17 mos.	1	Enjoys picture book & can turn pages		
	2	Uses jargon & a few clear words in conversation at least one to an utterance		
	3	By 17 mos. uses 6 or 7 words w/meaning		
18-23 mos.	1	Continues to jabber tunefully to himself at play		
	2	Echoes prominent or last word addressed to him		
	3	Names at least 1 picture of 5 common objects (cat, dog, man, baby, ball)		
	4	Locates two objects hidden by examiner as child watches (2 out of 3 trials)		
	5	Joins 2 or more words in speech		
	6	Uses me and you		
	7	Matches 3 body parts of self & doll		
24-29 mos.	1	Recognizes fine detail in pictures		
	2	Refers to himself by name		
	3	Constantly asking name of objects		
	4	Shows correctly & repeats words for hair hands, feet, nose, eyes, mouth on request		
	5	Responds correctly to two of three commands: Give me the ball, put the block in the cup, put the block on the table		

Child's Name____________________**Child Development Worker**____________________

COGNITIVE, LINQUISTIC & VERBAL

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
24-29 mos. (cont.)	6	Identifies self in mirror (by pointing to self or verbalizing)		
	7	Has size concept (big & little)		
	8	Uses plurals		
	9	Answere correctly "What do you hear with?" (pointing or saying ears)		
30-35 mos.	1	Knows full name (1st & last)		
	2	Continually asks questions beginning - What, Where		
	3	Does some color matching w blocks (1 out of 3 trials)		
	4	Identifies action in pictures		
	5	Names one color		
	6	Identifies object by use-"What do we drink out of?", "What do we eat with," etc.		
	7	Understands concept of 1 (Show me one finger, etc.)		
	8	Comprehends cold, tired, hungry - What do we do when we're cold?, etc.		
	9	Can answer Are you a boy or a girl?		
3-4 yrs.	1	Comprehends 3 of 5 prepositions - on, off, under, out, in.		
	2	Speaks in approximately 6 word sentences		
	3	Gives a label to own drawing		
	4	Shows some appreciation of past & present		
	5	Relates experience & describes activities		
	6	Uses most frequently words-I, it, you, that, a, do, this, not, the		
	7	Matches pictures (at least 2 of matched set of 4)		
	8	Has a concept of 2 or more		
4-5 yrs.	1	Can name 1 primary color correctly		
	2	Matches 4 primary colors		
	3	Reads by way of pictures		
	4	Can group objects-(food, animals, toys,) and name the group		

Child's Name____________________**Child Development Worker**__________________________

COGNITIVE, LINQUISTIC, & VERBAL

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
4-5 yrs (cont.)	5	Counts 4 objects & answers how many		
	6	Listens to & tells long stories - sometimes confusing fact & fantasy		
	7	Can answer sensibly why do we have houses, books, clocks, eyes, ears (at least 3)		
	8	Appreciates past, present, & future		
5-6 yrs.	1	Speaks fluently and correctly except for confusions of s/f/th		
	2	Asks meaning of words		
	3	Names 4 primary colors		
	4	Learns left from right		
	5	Tells age & address & sometimes birthday		
	6	Can count to 10 meaningfully		
	7	Knows all body parts		
	8	Knows coins penny, nickle, dime		
	9	Can distinquish weight differences (Heavy, light)		
	10	Can tell similarities & differences familiar to his environment (city living as compared w/farm living, similarities & differences in neighborhood structures & families, etc.)		

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Child's Name____________________ Child Development Worker________________________

GROSS MOTOR

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
1 mo.	1	Rooting & sucking reflex		
	2	Lifts head slightly from prone position & maintains position for 5 seconds		
	3	Ventral suspension from prone - head droops		
	4	Straightens leg when pressure is applied to bottom of feet		
	5	Fencing position w/head & arms (assymetrical tonic reflex should disappear by at least 6 mos.)		
	6	Head lags, falls back when pulled to sit		
	7	When placed in sitting position-head slumps forward on chest; back is evenly rounded		
	8	On flat surface head rotates-baby makes small crawling movements-legs in fetal position		
2 mos.	1	Lying on stomach - baby can lift head		
	2	Reflexive reciprocal kicking		
	3	Head erect & bobbing when in sitting position		
3 mos.	1	Rolls from side to side, left & right		
	2	When lying on stomach, rests on forearms raising head and chest		
4 mos.	1	Hands are usually near face & chest - uses both hands in unison		
	2	Ventral suspension from prone - baby holds Head up		
	3	Props body up on forearms-tends to fall on side-just on verge of rolling to supine		
	4	Legs are stretched out		
5 mos.	1	Lifts head from supine		
	2	When supported sitting baby's back is sturdy-head erect but set forward & steady		
6 mos.	1	Rolls to stomach		
	2	Lifts legs high - holds them out straight		
	3	Grips object w/whole hand voluntarily - Palmar grasp		
7 mos.	1	Brings feet to mouth		
	2	Sits on hard surface-trunk erect w/minimal support-adults hands on hips-head & trunk aligned		
	3	When held in standing position child bounces		

Child's Name____________________Child Development Worker____________________

GROSS MOTOR

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
8 mos.	1	Creeping or belly crawling-abdomen is dragged over supporting surface using mainly shoulders & elbows - legs remain extended		
	2	Independent sitting balance		
	3	Bridging movements-when lying on back, bends knees-puts feet on support-lifts hips to make bridge		
	4	Forward & backward creeping or crawling - abdomen raised weight supported		
9 mos.	1	Pulls to standing position		
	2	When hands supported will maintain standing position for at least 5 minutes		
	3	When hands are supported can make stepping movements in place		
	4	Can sit alone & change positions w/out falling		
10-12 mos.	1	Begins cruising-sidestepping around furniture		
	2	Walks w/one or both hands held		
	3	Is able to stand alone for at least 1 min.		
13 mos.	1	Stands alone with feet apart		
	2	Bends and regains balance w/support		
	3	Can crawl up one step		
14-15 mos.	1	Can maintain kneeling position at least 1 min.		
	2	Walks independently but may still fall occasionally		
	3	Can crawl up several steps		
16-17 mos.	1	Runs flatfooted - eyes fixed on ground		
	2	Pushes toys both standing erect & bending		
18-20 mos.	1	Walks up stairs - one hand held		
	2	Throws ball overhand		
	3	Kicks ball forward after demonstration		
	4	Backs into small chair to sit - climbs forward into adult chair then turns to sit		
21-23 mos.	1	Walks downstairs - one hand held		
	2	Jumps up & down in place		

Child's Name____________________Child Development Worker____________________

GROSS MOTOR

Age	No.	Developmental Tasks	No/Date	Yes/Date
24-29 mos.	1	Runs w/ease-stopping, starting & avoiding obstacles		
	2	Squats to rest & rises to feet without using hands		
	3	Walks up & down stairs holding rail two feet on each step		
	4	Walks on tiptoes at least two steps		
	5	Walks backward 10 feet		
30-35 mos.	1	Jumps distance of 4-14 in. or jumps over string 2 in. high		
	2	Walks up & down stairs alternating feet		
	3	Hops on one foot - 2 or more hops		
	4	Can stand on tiptoe after demonstration		
3-4 yrs.	1	Pedals a trike		
	2	Can turn around obstacles while running & while pushing or pulling big toys		
	3	Can balance on one foot 2-5 sec.		
	4	Can walk a line at least 5 ft. heel to toe		
	5	Uses shoulder & elbow in throwing ball		
	6	Catches ball when bounced		
4-5 yrs.	1	Turns sharp corners running, pushing, pulling		
	2	Climbs ladders & jungle gym equipment		
	3	Pedals trike & guides it around obstacles		
	4	Can run on tiptoe		
	5	Maintains balance on beam at least 4 inches off ground		
	6	Walks backward heel to toe		
5-6 yrs.	1	Can stand on one foot 8-10 sec.		
	2	Skips on alternate feet		
	3	Strong grip w/either hand		
	4	Hops 2-3 yds. forward on each foot separately		
	5	Can jump rope		

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Child's Name____________________Child Development Worker____________________

FINE MOTOR

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
0-1 mo.	1	Closes eyes against glare of bright light		
	2	Looks at object for 5 seconds		
	3	Clenches finger on contact		
	4	Hands fisted rest near or in mouth		
	5	Body movements are reflexive not voluntary		
2 mos.	1	Can follow moving object (rattle, ball) horizontally or vertically for 10 seconds		
	2	Moves arms vigorously when awake & lying on back		
	3	Can hold rattle for 5-10 sec. then drops it		
3 mos.	1	Follows moving object in circle w/eyes when in supine position		
	2	When held sitting or when lying looks at own or adult's moving fingers		
	3	Glances at rattle placed in hand for 5-10 sec.		
4 mos.	1	Opens hand, looks at & plays w/fingers-puts hands in mouth		
	2	Reaches for & grasps a rattle at midline		
	[illegible]	Visually explores surroundings		
5 mos.	1	Clutches a dangling toy		
	2	Puts toys to mouth		
	3	Grasps one small block & looks at second		
	4	Reaches for a toy w/one hand		
6 mos.	1	Transfers toy from hand to hand		
	2	Picks up block that has been dropped		
	3	When sitting pats palm of hand against surface		
	4	Is able to grasp 2 small blocks - one in each hand		

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Child's Name__________________Child Development Worker____________________

FINE MOTOR

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
7 mos.	1	Holds rattle 3-5 minutes		
	2	Bangs toys against surface		
	3	Pulls strong to attain toy		
	4	Looks in direction of lost toy		
8 mos.	1	Has voluntary Palmar grasp		
	2	Hits one block against another		
	3	Will drop one block to secure a third		
9 mos.	1	Beginning to grasp w/thumb & forefinger bits of food		
	2	Holds toy in one hand & plays w/string attached to another toy		
	3	Watches adult place toy under box and attempts to lift box to find toy		
	4	Shakes box w/block inside to hear noise		
10 mos	1	Pokes at things w/index finger		
	2	Throws toys		
	3	Removes lid from box		
	4	Will attempt to pick up 3 blocks w/the third between the two in either hand		
11-12 mos.	1	Uses index finger to point		
	2	Can remove small object from cup - raisin		
	3	Picks up small object (bits of food) w/thumb & forefinger		
	4	Drops toys and watches them fall		
	5	Searches in proper place for toys that have gone out of sight		
	6	Builds tower of 2 blocks - (1" cubes)		
13-15 mos.	1	Imitates scribbling w/pencil after demonstration		
	2	Rolls a ball to adult		
	3	Removes & replaces round object in formboard		
	4	Is able to hold 3 blocks - one in one hand two in other (1" cubes)		
	5	Puts in & takes blocks out of box without demonstration		

Child's Name____________________Child Development Worker________________________

FINE MOTOR

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
16-17 mos.	1	Can build tower of 3 or 4 blocks (1" cubes)		
	2	Scribbles spontaneously w/pencil		
	3	Places square shape in formboard		
	4	Is able to place lid on box		
18-23 mos.	1	Turns pages of book 2-3 at a time		
	2	Begins to use one hand more often than other		
	3	Turns knob on toy radio		
	4	Places 6 round pegs in holes		
	5	Imitates vertical line		
	6	Places 3 forms correctly on formboard - triangle, circle, and square		
	7	Builds tower of 6 blocks (1" cubes)		
	8	Makes circular scribble after demonstration		
24-29 mos.	1	Turns pages singly		
	2	Takes things apart & puts together 5 piece stacking cups or rings		
	3	Imitates vertical & horizontal line		
	4	Manipulates egg beater 1 of 3 trials		
	5	Imitates folding paper		
	6	Imitates making train of cubes		
30-35 mos.	1	Vertical & horizontal building w/blocks		
	2	Holds crayon or pencil by fingers instead of whole hand		
	3	Makes a bridge of blocks after demonstration		
	4	Closes fist & moves thumb after demonstration		
	5	Two lines - picks longest or smallest one on request		
	6	Strings beads - at least four (1" square or round)		

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Child's Name____________________Child Development Worker____________________

FINE MOTOR

Age Level		Developmental Tasks	No/Date	Yes/Date
3-4 yrs.	1	Cuts w/blunt scissors manipulates scissors & cuts through a 2" strip of paper		
		Picks up pins,thread, etc.- each eye covered separately		
	3	Attempts to lace shoes		
	4	Draws head of man and one other part after demonstration		
	5	Can touch thumb to 2 of 4 fingers on same hand		
	6	Imitates line drawings of capital letters or numbers		
4-6 yrs	1	Draws a man on request w/at least two parts		
	2	Draws a simple house (roof, door, window)		
	3	Copies cross and square		
	4	Traces over a line drawing of a star		
	5	Builds a tower of 10 or more cubes		
	6	Prints capital letter using first letter of name on request'show me how to write you name'		
5-6 yrs	1	Copies a triangle		
	2	Writes a few letters spontaneously		
	3	Draws recognizable man with features on man		
	4	Counts on fingers on one hand with index finger of other hand		
	5	Frequently reverses letters in copying or drawing spontaneously		
	6	Prints numbers 1-5		
	7	Adds 7 parts to incomplete man		
	8	Learns to lace shoes or can lace own shoe after demonstration		

ALLIED AGENCIES DEVELOPMENTAL TRAINING PROGRAM 33

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Peoria Assn. for Retarded Citizens & United Cerebral Palsy of Northwestern Ill.

Child's Name______________________ Child Development Worker______________________

EATING

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
1 mo.	1	2 night feedings		
2 mos.	1	1 night feeding		
3 mos.	1	Sucks pureed food off spoon		
	2	Coordinates sucking, swallowing & breathing		
	3	Sleeps 4-10 hrs. at night w/out a feeding		
4-6 mos.	1	Recognizes bottle on sight - searches for nipple w/mouth when bottle is in line of vision		
	2	Uses tongue to move food in, out, and inside mouth		
	3	Gums solid foods		
	4	Feeds self cracker		
	5	Able to drink from cup when held for him		
	6	Lifts empty cup in imitation		
7-11 mos.	1	Picks up spoon - bangs in imitation		
	2	Finger feeds - dry cereal, bits of meat, vegetables		
12-17 mos.	1	Holds own cup to mouth for drinking but may spill some		
	2	Can take full spoon to mouth but may spill some-difficulty in inserting spoon in mouth-may turn bowl over		
	3	Chews well		
	4	Refuses foods he doesn't like-turns head away-closes mouth tightly		
18-23 mos.	1	Lifts cup & drinks - bottle discarded		
	2	Inserts spoon in mouth w/out turning bowl		
24-29 mos	1	Drinks from cup-replaces on table-plays w/food		
30-35 mos.	1	Feeds himself at least first half of meal unassisted		
	2	Eats skillfully w/spoon - can scoop & insert food without spilling		
3-4 yrs	1	Pours from pitcher without spilling		
	2	Eats with fork and spoon		
	3	Likes to help set table		

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Child's Name________________________Child Development Worker________________________

EATING

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
4-5 yrs.	1	Spreads butter on bread with knife		
	2	Uses fork without spilling		
	3	Attempts to cut up food		
5-6	1	Uses knife and fork properly		
	2	Uses napkin		

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Child's Name____________________ Child Development Worker____________________

DRESSING

Age Level		Developmental Tasks	No/Date	Yes/Date
12-17 mos.	1	Cooperates in dressing - extends arm or foot		
	2	Removes shoes and socks		
18-23 mos.	1	Takes off clothes, needs help w/buttons		
	2	Attempts to put on shoes		
	3	Can unzip front and side zippers		
24-29 mos.	1	Puts on pants or shorts-may put on backwards		
	2	Puts on shoes and hats		
30-35 mos.	1	Undresses completely		
	2	Needs supervision and help to dress; can put on socks		
	3	Can unbutton front buttons		
	4	Puts on coat or dress unassisted		
3-4 yrs.	1	Pulls on shoes		
	2	Intent on lacing shoes; (usually does incorrectly)		
	3	Buttons coat or dress		
4-5 yrs	1	Dresses self except for tying shoes		
	2	Distinguishes front and back of clothes		
5-6 yrs	1	Buttons 2-4 buttons		
	2	Undresses and dresses alone		
	3	Can tie single knot - may be able to tie own shoes		
	4	Can brush and comb hair successfully		

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ALLIED AGENCIES DEVELOPMENTAL TRAINING PROGRAM
Co-sponsored By
Peoria Assn. for Retarded Citizens & United Cerebral Palsy of Northwestern Ill.

Child's Name____________________ Child Development Worker____________________

TOILET TRAINING

Age Level	No.	Developmental Tasks	No/Date	Yes/Date
9-12 mos.	1	Beginning to show regular patterns in bladder and bowel elimination		
	2	Has 1-2 stools a day		
	3	Interval of dryness does not exceed 1-2 hrs.		
	4	Shows discomfort when wet or soiled		
13-18 mos.	1	Will sit on nursery chair for short periods		
	2	Child can control bowel movement; the Sphinctermuscle has developed		
	3	Will have bowel movement if put on toilet at appropriate time		
18-20 mos.	1	Indicates toilet needs by restlessness or vocalization		
	2	Bladder control transitional, 1-2 accidents per day		
24-29 mos.	1	Verbalizes toilet needs in reasonable time		
	2	Some word for both functions		
	3	Will go to toilet for urination - will pull pants down		
	4	Will go to toilet by self for bowel movement		
	5	Dry during the day		
	6	Requires assistance (reminding, dressing, wiping)		
	7	Makes inadequate attempts to wash hands		
30-35 mos.	1	Is able to pull pants up and down		
	2	Will go to toilet by self for urination		
	3	Seldom has accidents with bowel movements		
3-4 yrs.	1	Can flush toilet after use		
	2	Can wash hands after toileting		
4-5 yrs.	1	Stays dry at night		
	2	Seldom has accidents with urination		
5-6 yrs.	1	Seldom needs to be reminded for toileting		
	2	General independence		

FUNCTIONAL CHECKLIST FOR THE DEVELOPMENTAL 0-3 PROJECT

Cattell Infant Intelligence Scale (New York: Psychological Corporation, 1940).

Denver Developmental Screening Test (Boulder, Colorado: University of Colorado Medical Center, 1966).

Rose C. Engel, *Language Motivation Experience for Young Children* (Van Nuys, California: D.S.E. Publisher).

Arnold Gesell and Associates, *The First Five Years of Life* (New York: Harper & Brothers, 1940).

Gesell Developmental Schedule (New York: Psychological Corporation).

Ruth E. Hartley and Robert M. Goldenson, *The Complete Book of Children's Play* (New York: Thomas Y. Crowell Company, 1963).

Una Haynes, *A Developmental Approach to Casefinding* (U.S. Department of Health, Education and Welfare: Children's Bureau Publication #449).

Slosson Intelligence Test (East Aurora, New York: Slosson Educational Publications, 1963).

Catherine C. Sprugel and Sheila Goldberg under direction of Merle B. Karnes, *Developmental Guidelines, Compiled from Selected Sources* (Urbana, Illinois: PEECH Project, University of Illinois), duplicated.

Washington Developmental Scale

This developmental checklist was compiled from the selected resources listed above. It is used by the Child Development Workers on the Peoria 0-3 Project to determine a level of functioning and to aid in program planning for each child.

RAPID DEVELOPMENTAL SCREENING
CHECK LIST

This check list is a compilation of developmental landmarks matched against the age of the child. These are in easily-scored question form and may be checked YES or NO by a physician or his aid, by direct observation.

"NO" responses at the appropriate age may constitute a signal indicating a possible developmental lag. If there is a substantial deviation from these values then the child should be evaluated more carefully, taking into consideration the wide variability of developmental landmarks. (Adjust for prematurity, prior to two years, by subtracting the time of prematurity from the age of the child. E.G., a two-month-old infant who was one month premature should be evaluated as a month-old infant).

It is our hope that the early recognition of such lags would lead to early diagnosis and treatment, the results of which can be very helpful to many of these children.

NAME ______________________________ D.O.B.: __________ 1st Visit Date ________

AGE				DATE
1 Month	Can he raise his head from the surface while in the prone position?...........	___YES	___NO	
	Does he regard your face while you are in his direct line of vision?	___YES	___NO	
2 Months	Does he smile and coo?	___YES	___NO	
3 Months	Does he follow a moving object?	___YES	___NO	
	Does he hold his head erect?	___YES	___NO	
4 Months	Will he hold a rattle?	___YES	___NO	
	Does he laugh aloud?	___YES	___NO	
5 Months	Can he reach for and hold objects?	___YES	___NO	
6 Months	Can he turn over?	___YES	___NO	
	Does he turn toward sounds?	___YES	___NO	
	Will he sit with a little support (with one hand)?	___YES	___NO	
7 Months	Can he transfer an object from one hand to another?	___YES	___NO	
	Can he sit momentarily without support?	___YES	___NO	
8 Months	Can he sit steadily for about five minutes?	___YES	___NO	
9 Months	Can he say "ma-ma" or "da-da"?	___YES	___NO	
10 Months	Can he pull himself up at the side of his crib or playpen?	___YES	___NO	
11 Months	Can he cruise around his playpen or crib, or walk holding on to furniture?	___YES	___NO	
12 Months	Can he wave bye-bye?	___YES	___NO	
	Can he walk with one hand held?	___YES	___NO	
	Does he have a two-word vocabulary? ...	___YES	___NO	
15 Months	Can he walk by himself?	___YES	___NO	
	Can he indicate his wants by pointing and grunting?	___YES	___NO	
18 Months	Can he build a tower of 3 blocks?	___YES	___NO	
	Does he say six words?	___YES	___NO	

AGE				DATE
24 Months	Can he run?	___YES	___NO	
	Can he walk up and down stairs holding rail?	___YES	___NO	
	Can he express himself (occasionally) in a two word sentence?	___YES	___NO	
2½ Years	Can he jump lifting both feet off the ground?	___YES	___NO	
	Can he build a tower of six blocks?	___YES	___NO	
	Can be point to parts of his body on command?	___YES	___NO	
3 Years	Can he follow two commands involving "on", "under", or "behind"? (without gestures)	___YES	___NO	
	Can he build a tower of nine blocks?	___YES	___NO	
	Does he know his first name?	___YES	___NO	
	Can he copy a circle?	___YES	___NO	
4 Years	Can he stand on one foot?	___YES	___NO	
	Can he copy a cross?	___YES	___NO	
	Does he use the past tense, properly?	___YES	___NO	
5 Years	Can he follow three commands?	___YES	___NO	
	Can he copy a square?	___YES	___NO	
	Can he skip?	___YES	___NO	

The Replication Staff suggests that this checklist might be a useful tool for nurses.

Developed by the Committee on Children with Handicaps American Academy of Pediatrics, New York Chapter 3, District II.

A SAMPLE 0-3 HOME PROGRAM FOR THE EARLY INTERVENTION OF A DOWN'S SYNDROME INFANT

Jimmie, an eight week old infant, was diagnosed by the family physician as Down's Syndrome and was referred to Allied Agency for a developmental evaluation.

An initial intake was done by the agency social worker. It was felt by the social worker that a homebound program might be beneficial for Jimmie. The case was assigned to a Child Development Worker who scheduled all the necessary evaluation appointments for the child.

The parents were contacted and given appointment dates. Jimmie was three months old at the time of this contact. However, due to a respiratory infection which required hospitalization, the evaluation procedure did not begin until age four months.

Performance on the Denver Developmental Screening Test, when administered by the nurse, revealed a lag in the gross motor area. At age four months the child was found to be functioning at the two to three month level. Results of the Receptive Expressive Emergent Language Scale administered by the Speech and Language Therapist indicated a Language Age of five months, one month above the chronological age level.

The agency physician, who serves as a consultant in the area of genetics, conducted a study. The diagnostic results indicated "Karyotype consistent with Primary Trisomic Down's Syndrome" of which prognosis is poor.

After all evaluations were completed a 0-3 staffing was held. Immediate implementation of a home program was recommended.

Activities were planned by the Child Development Worker designed to facilitate growth in the areas of delay. These were delivered monthly to the home.

Typical activities used to stimulate the development of a Down's Syndrome Infant were utilized throughout the home program.

VISIT 1 Suggested Activities
3-25-74
- Activities were delivered to the home to stimulate gross and fine motor development including:

  tracking
  stretching
  extending and rotating arms
  attending
  proper positioning

VISIT 2 Observations
- Jimmie's head and trunk control were improving. However, the infant was not ready for independent sitting.

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Suggested Activities

- Use small 1" cubes to encourage grasping
- Use a mirror to stimulate self-image
- Use noisemakers to encourage tracking eye left to right and to strengthen back, neck, and eye muscles.

VISIT 3
5-31-74

Observations

- Jimmie was almost ready for independent sitting.

Suggested activities

- introduction and demonstration of adapted infant seat

VISIT 4
6-28-74

Observations

- sitting has improved
- he is having difficulty getting finger food to his mouth
- continue sitting exercises beginning to lengthen time spent on each exercise.

VISIT 5
7-25-74

Observations

- infant can now sit alone
- he is grasping and playing appropriately with noise-making toys
- he can transfer object from hand to hand

Suggested Activities

- activities were demonstrated to help child support himself in a crawling position.
- continue feeding suggestions using jelly and honey.
- introduction to the straw, bottle, and straw cup
- demonstration of use of therapy roll
- demonstrate how to exercise baby over mother's leg to strengthen trunk, back, and neck muscles.

VISIT 6
8-25-74

Observations

- infant is now one year old and developmental lag is more noticeable in all areas.
- child is now ready for a structured language program.
- gross and fine motor programs must be continued to encourage and strengthen muscles for the development of walking.

Formats for lesson plans are presented in the following three pages.

Child's Name ______________________________

ACTIVITY CHART 40

Home Trainer's Name ______________________________

Week of ______________________________

BEHAVIOR:

Will pull toward him an object on a blanket.

Days ______________________________

Purpose

Attending

DIRECTIONS:

DAYS

1. Place toy with string attached on a blanket in front of the child with the string within the child's reach.
2. Tell your child "Pull the toy."
3. If your child does not reach for the string physically assist him to do so.
4. As the toy moves praise your child for pulling.
5. Let him hold the toy and play with it briefly.

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Child's Name ____________________

Home Trainer's Name ____________________

Week of ____________________

ACTIVITY CHART 41

BEHAVIOR:

Child will grasp and hit

two blocks together.

DAYS

DIRECTIONS:

1. Give your child two small blocks and tell him what they are.
   Give physical assistance to grasp and hit them together if necessary.

2. Practice hitting them together as you talk about what you are doing.

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Child's Name ____________________ ACTIVITY CHART 42

Home Trainer's Name ______________

Week of ______________________

BEHAVIOR:

The child will track a rattle and look at the body part on which it is placed.

Purpose:

1. Attending
2. Tracking
3. Tactile awareness

DIRECTIONS:

DAYS

1. With the child sitting in front of you, put the rattle in his hand (help the child grasp rattle) and let the child shake the rattle.
2. Shake the rattle in front of child's eyes. When the child looks at the rattle, move the rattle up and then down.
3. If necessary move the child's head up and down, fade physical assistance.
4. Reinforce the child when he tracks the rattle.
5. While the child is tracking the rattle, quickly move the rattle and place against a part of the child's body. Shake rattle as you hold it against the child.
6. If necessary help the child move his head to look at the rattle (on his body). Fade physical assistance.
7. Reinforce child when he looks at the rattle.

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COMMONALITIES FOR ALL CHILDREN

Whether you teach so-called "normal" or handicapped children, there are more commonalities than differences. Needs are basic -- only ways of meeting them may differ.

The following are suggestions that may help you with your children.

A. ALL CHILDREN

1. Adapt the environment or situation so that each child can be part of the activities enjoyed by others in the group.
2. Be a good language model.
3. Care for him rather than always taking care of him.
4. Encourage the child to verbalize his needs rather than anticipating them. In a situation where there is some problem in relation to another child, help him use a verbal rather than physical approach.
5. Encourage free physical movement.
6. Expect the standards of courtesy and waiting expected of others. A handicap is not to be used to take advantage of the rights of others.
7. Give him opportunities to help others. He is so often on the receiving end.
8. Help the child develop and use any auditory ability he may have.
9. Listen! Give him time to talk by waiting for his response and try not to answer for him.
10. Repeat but vary the situation to keep the child interested.
11. Respect the contribution and opinion of each child.
12. Show him what is expected before asking him to do it.
13. Talk about what is going on to help him not only look but to see.
14. Use concrete experiences.
15. Use multi-sensory approach.
16. Use many kinesthetic experiences and sensory art activities to encourage manual dexterity and manipulation.
17. Work for communication and praise child for each success, remembering that receptive language always precedes expressive language.
18. Work with parents and therapists. Parents are the prime educators of their children.

B. PHYSICALLY HANDICAPPED

1. If all the others are on the floor or grass for an activity, get him out of the wheelchair and down with the others.
2. Give him the time to do whatever he is physically capable of doing for himself.
3. These children particularly need to use their bodies.
4. If he is unable to go to things, bring them to him.
5. Take advantage of the fact that classroom situations can reinforce patterns learned in therapy.

C. DEAF CHILDREN

1. Let him see. Closing off his vision is like putting earmuffs on a child who is blind.

2. Use simple sentences rather than single words to facilitate language development.
3. Encourage the child to express himself in some language medium such as 1) speech, 2) finger spelling, or 3) written.
4. If he has a hearing aid, he is to use it.
5. In presenting new vocabulary, remember the importance of repetition. Try to use the new word in every sentence so the child will recognize it on your lips and associate the word with the object or action.
6. He only understands what he can see.
7. Never take anything for granted when speaking to the deaf child. Take the time to explain everything no matter how simple it may seem by asking the child to repeat what was said, by asking him a question about what was said or by having him show what was done.
8. Use simple pictures to clarify ideas when the concrete object is not available. Until he has developed a mental clue, he needs to see the visual clue. Use all possible media including: charts, blackboard, picture flash cards with labels, auditory stimulation, hearing aids--group and individual.
9. Sense of touch helps to round out what he sees.
10. Bombard him with language on his level. Use the same name for an object until he understands it. Call a dog a dog. Interchanging dog, doggie, pup, puppy, Spot, etc., adds confusion.

D. BLIND CHILDREN

1. Tell him what is going on. When you touch him, tell him who you are. Teach other children to identify themselves when touching him.
2. Let him make as many movements as possible by himself. Tell him to"come to your voice". Let him open doors with his own effort, when possible.
3. Thoughtfully arrange the environment for free movement with safety. Encourage independence.
4. Hearing is his main channel for learning. Don't be afraid of a sensory overload on this channel for the blind.
5. Listen and refuse a request if you need to but do not ignore by not responding.
6. Many of their concepts are built and clarified by what they hear. Tell him where and why he is going before moving him. Talk about the type of flooring they are crossing such as "Now you are on the grass (cement, asphalt, tile, wooden floor)".
7. "Puppy" is only a word until experience of its warm, wiggling tail-wiggling tail-wagging, cold nose and wet tongue add meaning.
8. Sense of touch helps to round out what he hears.

Engel, Rose C. Language Motivating Experiences for Young Children.

Kravitz, Harvey, M. D. Hand to Body Discovery and Play in Normal Infants. Chicago: Children's Memorial Hospital.

Developmental Norms for Infant Hand to Body Play

Activity	Median Age	Range
hand to eye	4 wks	2 to 9 wks
hand to head	6 wks	2 to 13 wks
hand to nose	9 wks	2 to 17 wks
hand to hand	12 wks	4 to 16 wks
hand to body	15 wks	8 to 18 wks
hand to knee	16 wks	9 to 22 wks
hand to foot	19 wks	11 to 27 wks
hand to penis	23 wks	14 to 39 wks

American Medical Association. Month-To-Month Guide to Your Child's Development.

1 month	lift chin off table
2 months	lift chest off table
3 months	unsuccessfully reach for objects
4 months	sit with support
5 months	sit on your lap and grasp small objects
6 months	sit in a high chair and grasp a dangling object
7 months	sit alone
8 months	stand with help
9 months	stand by holding on to furniture
10 months	creep
11 months	walk, if led by one hand
12 months	pull up and stand with furniture as support
13 months	climb (crawl) up a few stairs
14 months	stand alone
15 months	walk alone

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CURRICULUM GUIDES

Engel, Rose C. Language Motivating Experiences for Young Children. Van Nuys, California: DFA Publishers, 1968.

Gawiser, P., et-al. Piagetian Based Infant Stimulation Curriculum Ohio State University: The Nisonger Center, 1972.

Instructional Materials Center. Preschool Learning Activities for the Visually Impaired Child: A Guide for Parents. Springfield, Illinois: Office of the Superintendent of Public Instruction, 1973.

Karnes, Merle. Fostering Early Education Development Through Motor, Visual, and Auditory Activities. Not yet available for publication.

Karnes, Merle. GOAL: Game Oriented Activities for Learning. Springfield, Massachusetts: Milton Bradley Company.

Karnes, Merle. Helping Young Children Develop Language Skills: A Book of Activities. Washington, D.C. : The Council for Exceptional Children, 1968.

The Portage Project. The Portage Guide to Early Education. Portage, Wisconsin: The Cooperative Educational Service, Agency 12.

CHILD DEVELOPMENT BIBLIOGRAPHY

Baird, Henry W. *The Child With Convulsions*. New York: Grune and Stratton, 1972.

Beadle, Muriel. *A Child's Mind*. Garden City: Anchor Books, 1971.

Butler, Dr. Annie L. *Headstart for Every Child*. The Associated Press, 1972.

Finnie, Nancie R. *Handling the Young Cerebral Palsied Child at Home*. New York: E.P. Dutton and Co., 1970.

Frailberg, Selma H. *The Magic Years*. New York: Scribner, 1959.

Fry, Margery. *Child Care and the Growth of Love*. Baltimore: Penquin Books, 1965.

Gilbert, Sara. *Three Years to Grow*. New York: Parents Magazine Press, 1972.

Gordon, Ira. *Baby Learning Through Baby Play*. New York: St. Martin's Press, 1970.

Ingles, Ruth Langdon. *A Time to Learn: A Guide for Parents to New Theories in Early Education*. New York: Dial Press, 1973.

Isaacs, Susan Sutherland. *The Nursery Years: The Mind of a Child from Birth to Six Years*. New York: Schockm Books, 1968.

Kremer, B. Parent Education: Abstract Bibliography. Urbana, Illinois: University of Illinois, Eric Clearinghouse on Early Childhood Education, 1971.

Painter, Genevieve. *Teach Your Baby*. New York: Simon and Schuster, 1971.

McDonald, E.T. *Understand Those Feelings: A Guide for Parents of Handicapped Children and Everyone Who Counsels Them*. Pittsburgh: Stanwix House.

Patterson, Gerald R., and Gullion, Elizabeth M. *Living With Children: New Methods for Parents and Teachers*. Champaign: Research Press Co., 1971.

Thorum, Arden R. *Your Child's Intellect*. Olympus Publishing Co., 1972.

Weiner, Florence. *Help for the Handicapped Child*. New York: McGraw-Hill, 1973.

ADDRESSES FOR CURRICULUM MATERIALS

Nebraska Ladders:

Mr. Al Hansen
Community Regional Services, Inc.
2611 S. 46th Street
Lincoln, Nebraska 68506

The Marshalltown Project:

Department of Special Education
Marshall-Poweshiek Joint County School System
A Westwood Drive
Marshalltown, Iowa 50158

Karnes Early Language Activity:

Published by Generators of Educational Material
Box 2339
Post Office Station A
Champaign, Illinois 61820

Getting Ready to be a Parent
Pre-School Developmental Kit
Moline Public Schools
District #40
Moline, Illinois

A Planning Guide
The Preschool Curriculum
The Child
The Process
The Day
Chapel Hill Training-Outreach Project
Distributed By:
Kaplan School Supply Corp.
600 Jonestown Road
Winston-Salem, N.C. 27103

Levy, Dr. Janine, *The Baby Exercise Book* (New York: Random House, Inc. 1973).

The Home Program for Speech and Language Development used in conjunction with the 0-3 project is an adaptation of the Correlated Language Program developed by the Speech and Language Staff of Peoria Association for Retarded Citizens. In order to better understand the component parts of the home program, basic knowledge of the Correlated Language Program is a necessity. The following provides a brief description.

I. Rationale

To provide:

1. A structured format for individual and small group speech and language therapy.

2. A comprehensive therapy-related classroom program designed to broaden therapy experiences for those children who receive speech and language therapy.

3. A classroom language program for children who do not display the need for individual or small group speech and language therapy but who could benefit from exposure to structured language experiences.

4. An effective resource person in the area of speech and language for the classroom teacher.

II. Format

1. The program consists of five basic classifications to be taught in six week segments both in the classroom and in individualized speech and language therapy. The classifications are:

    a. Body parts
    b. Toys
    c. Foods
    d. Clothing
    e. Common objects

2. Activities contained within each classification are based on the following developmental sequence of language acquisition:

    a. Attending
    b. Non-verbal mimic
    c. Verbal mimic
    d. Matching
    e. Identifying
    f. Labeling
    g. Phrasing
    h. Sentencing

3. Related concepts, spatial relationships, core vocabulary (nouns) action words, and pronouns to be taught within each classification are provided for the classroom teacher. See Appendix I.

4. The appropriate level of pre and post tests for each category are administered by the speech and language therapist to those children in individual and small group therapy to determine language needs. (See Appendix II for answer sheet).

    a. A composite is devised from test results to serve as an indicator for language needs within the classroom.

   b. Within a classroom two to three levels of language groupings may be necessary.

5. The speech and language therapy staff meets weekly to target language behaviors appropriate for each group within the classroom.

6. Language plans are delivered weekly to the classroom teacher along with data keeping forms. (See Appendix III). Included within each plan are:

   a. Developmental classification
   b. Targeted behavior
   c. Pre and post test
   d. Materials to be used in teaching the activity
   e. Daily teaching procedures

7. Data is collected weekly and analyzed by the speech and language therapist for use in continued planning. (See Appendix IV for data keeping form).

8. A speech therapist is scheduled weekly into each classroom to do language activities.

The Homebound Speech and Language Program is designed specifically to meet the communicative needs of children ages 0-3 years on an individualized basis. Parents, under the auspices of the speech and language therapist, work directly on speech and language development within the home setting. The following provides a brief description of the program format.

I. Rationale

To provide:

1. Stimulation for receptive and expressive language growth in accord with the normal developmental sequence of language acquisition.

2. Experiences which are basic to language development.

3. A meaningful structure for language learning.

4. An objective data keeping method for charting language growth over a given period of time.

II. Format

1. Speech and Language Evaluation

   a. The speech and language therapist administers diagnostic tests to determine level of language development and point of intervention. Test selection is dependent upon level of functioning and ability to participate.

   b. The following diagnostic instruments are used by the Peoria 0-3 Project. These tests are not to be considered all inclusive. See Appendix V for other available testing procedures.

      - Receptive Expressive Emergent Language Scale - Ages birth to 3 years, informant scale

      - Utah Test of Language Development - Ages 1 year to 15 years

      - Zimmerman Preschool Language Scale - Ages 1 year 6 months to 7 years

      - Peabody Picture Vocabulary Test - Ages 2 years 6 months to adult

      - Diagnostic Language Therapy

   c. Referral is made for palatal function evaluation if necessary.

2. Audiometric Evaluation

   a. Hearing screening is administered by the speech and language therapist if the child is able to participate. See Appendix VI for conditioning procedure.

   b. Referrals are made to the consulting audiologist for:

      - Impedance Bridge Audiometry if the child is severely involved or cannot be conditioned for audiometric testing.

- Audiological evaluation if a hearing loss is suspected.

- Hearing aid evaluations

c. Referral is made for an otological evaluation if recommended by the consulting audiologist.

3. Home Language Program

a. The speech and language therapist interprets test scores to the child development worker and plans the appropriate language program.

b. Long range goals are established by the speech and language therapist based on the developmental sequence provided by the Correlated Language Program.

c. The speech and language therapist along with the child development worker targets activities to work toward the long range goal(s). See Appendix VII for target recording form.

d. Lesson plans are written for or pulled from the Correlated Language Program by the therapist for each target to provide exact teaching procedures.

e. Materials appropriate for each lesson are developed by the speech therapist and/or child development worker to be taken into the home.

f. The child development worker individualizes the lesson plan. See Appendix VIII.

g. The child development worker takes plans and materials into the home, pre-tests child, and demonstrates the activity for the parent, and explains charting procedure.

h. The parent teaches the activity and charts responses. See Appendix VIII.

i. The child development worker returns to home, post-tests the child, and collects the charts kept by the parent. The next lesson plan is left and cycle repeats.

j. The child development worker records results of the pre- and post-test on the target recording form (See Appendix VII) as well as reporting the results to the speech therapist to be analyzed for use in continued planning.

k. The speech therapist re-evaluates the child as need arises or on a yearly basis.

APPENDIX I

ALLIED AGENCIES DEVELOPMENTAL TRAINING PROGRAM
Co-sponsored By
Peoria Assn. for Retarded Children Inc. & United Cerebral Palsy of Northwestern Ill. - Allied Agencies Center - 320 E. Armstrong Ave. - Peoria, Ill.61603

CORRELATED LANGUAGE PROGRAM

Classification: Common Objects

Core Vocabulary

Household Items

bed
chair
table
book
sink
toilet
T.V.
telephone
door
floor
window
sofa
pencil
paper
broom
iron
refrigerator
stove
vacuum cleaner
scissors
lights
bathtub
wastebasket
pillow
blanket
carpet
ceiling
wall
stairs
shelf
chest
closet
drawer
mirror
cabinet
dishwasher
record
record player
radio
pictures
washer
dryer
laundry basket
sheets
counter
ashtray
bookcase
desk
dresser
shower
faucet
ruler
pencil sharpener
bedspread
stereo
calendar
furnace
tools
bedroom
kitchen
living room
dining room
bathroom
laundry room
garage
basement
porch
patio

Related Concepts

heavy - light
same - not same - different
open - shut
on - off

Spatial Relationships

under
beside
between
above
below
over
top
middle
bottom

Action Words

read
write
put
cut
fold
watch
wash
dry
cook
sleep
mop
dust

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CORRELATED LANGUAGE PROGRAM

Classification: Common Objects

Core Vocabulary

Self Care Objects

comb
brush
soap
towel
toothbrush
toothpaste
kleenex
washcloth
toilet paper
shampoo
pins
band aid
bubble bath
medicine
deodorant
medicine cabinet
cologne
razor
shaving cream
rollers
make-up
nail polish
nail file
nail clippers
scale
talcum powder
cotton balls
gauze
bath oil
hand lotion
mouthwash
tweezers
Q-tips
hair cut
barber
beautician
manicure
permanent
infection

Related Concepts

sore
wet
dry
clean
dirty
swell
chapped
tangled
odor
long
short
curly
straight

Spatial Relationships

around
up
down
on
off

Action Words

shave
brush
rub
wash
dry
cut
dress
spray
comb
squeeze
blow
spit
curl
wipe

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ALLIED AGENCIES DEVELOPMENTAL TRAINING PROGRAM

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CORRELATED LANGUAGE PROGRAM

Classification: Common Objects

Core Vocabulary

Transportation

car
bus
train
boat
bicycle
tricycle
airplane
fire engine
truck
tractor
wheel
door
garbage truck
policeman
street
stop light
tire
jet
corner
seat belt
garage
steering wheel
headlight
tail light
motorcycle
taxi
parking lot
tunnel
parking meter
driveway
highway
traffic signs
engine
trunk
jack
tools
license
helicopter
pavement

Related Concepts

fast
slow
up
down
round
square
triangle
oval
rectangle
start
finish

Spatial Relationships

in
out
in front of
in back of
over
under
through

Action Words

stop
go
drive
steer
ride
pedal
fly
push
pull
inflate

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APPENDIX II.

Pre Test Date ______________________

Post Test Date ______________________

COMMON OBJECTS
Test I

Name: ______________________

I CORE VOCABULARY	EXPRESSIVE	RECEPTIVE	COMMENTS
1. car			
2. bus			
3. train			
4. comb			
5. table			
6. soap			
7. bed			
8. chair			
9. book			
II RELATED CONCEPTS			
10. up			
11. down			
12. wet			
13. dry			
14. clean			
15. dirty			
16. open			
17. shut			
18. on			
19. off			
III SPATIAL RELATIONSHIPS			
20. in			
21. out			
22. on			
23. under			
IV ACTION WORDS			
24. stop			
25. go			
26. comb			
27. wash			
28. cut			
29. sleep			

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Pre Test Date ______________________

COMMON OBJECTS
Test II

Post Test Date ______________________

Name: ______________________

I CORE VOCABULARY	EXPRESSIVE	RECEPTIVE	COMMENTS
1. wheel			
2. stop light			
3. garage			
4. medicine			
5. toilet paper			
6. shampoo			
7. carpet			
8. sheet			
9. closet			
II RELATED CONCEPTS			
10. circle			
11. square			
12. triangle			
13. start			
14. finish			
15. long			
16. short			
17. straight			
18. curly			
19. same			
20. different			
III SPATIAL RELATIONSHIPS			
21. in front of			
22. in back of			
23. around			
24. top			
25. middle			
26. bottom			
IV ACTION WORDS Phrasing			
27. ride bus			
28. fly kite			
29. drive car			
30. wipe hands			
31. squeeze sponge			
32. read book			
33. write numbers			

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Pre Test Date ____________________

COMMON OBJECTS
Test III

Post Test Date ____________________

Name: ____________________

I CORE VOCABULARY	EXPRESSIVE	RECEPTIVE	COMMENTS
1. nail clipper			
2. tweezer			
3. beautician			
4. transportation			
5. traffic signs			
6. tools			
7. faucet			
8. stereo			
9. counter			
II COGNITIVE - LINGUISTIC COMPETENCE			
10. house to downtown			
11. cleaning room			
12. preparing for school			
III RELATED CONCEPTS			
13. rectangle			
14. oval			
15. octagon			
16. tangled			
17. heavy			
IV SPATIAL RELATIONSHIPS			
18. through			
19. above			
20. between			
21. below			
V ACTION WORDS (SENTENCING)			
22. will comb			
23. combed			
24. drove			
25. will drive			
26. is dusting			
27. are dusting			
28. men sleep			
29. man sleeps			

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VII. Identifying A. Objects 1. Nouns d. Visual (3.) Foods	TARGETED BEHAVIOR: Student follows the direction "Drink the drink."	GOALS:
MATERIALS: Drinks in appropriate co Toy VARIATIONS: Use same levels for "Eat the food." Use manual communication when appropriate.	PROCEDURE: Level 1: Student drinks the drink when only the drink is present. Place the drink before the student and say "Drink the drink." Level 2: Student drinks the drink when it is in front of the toy. Place the drink in front of the toy and say "Drink the drink." Level 3: Student drinks the drink when it is to the right of the toy. Place the drink on the right side of the toy and say "Drink the drink." Level 4: Student drinks the drink when it is to the left of the toy. Place the drink on the left side of the toy and say "Drink the drink."	EVALUATION PROCEDURE: BEHAVIOR: DIRECTIONS:

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VII. Identifying A. Objects 1. Nouns d. Visual (3.)Foods	TARGETED BEHAVIOR: The student follows the direction "Drink the drink." SUCCESS:	GOALS: 1. Following directions
MATERIALS: Drinks cup, glass, or bottle toy **VARIATIONS:**	**PROCEDURE:** Day 1: Follow directions under evaluation procedure. Day 2: (Drink in appropriate container) 1. Put some milk in a glass and tell the student "We can drink the milk." 2. Drink some of the milk then say "Mm., the milk is good. We drink it." Use the gesture of drinking. 3. Place the drink the student likes before him and say "Drink the milk." 4. Assist the student until he can perform independently. Reinforce when appropriate. Days 3-4: (Toy, drink) 1. Place the drink and the toy before the student. 2. Say "Drink the milk." 3. Assist student until he can perform independently Reinforce when appropriate. Day 5: Follow directions under evaluation procedure.	**EVALUATION PROCEDURE:** **BEHAVIOR:** The student follows the direction "Drink the drink." **DIRECTIONS:** (Drink, Toy) 1. Place the drink and the toy before the student. 2. Say "Drink the milk." 3. Student picks up the drink and at least puts it to his mouth.

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APPENDIX IV

Date Jan. 25 through Jan. 31

Classification	Target	Goal
Common Objects	The student repeats the rapping pattern of the teacher	1. Matching 2. Auditory training

Child's Name	Day 1 Did child succeed? Yes	 No	Criteria	Day 5 Did child succeed? Yes	 No	
Doug	X		Doug, Jimmy, Paul went right through the lesson	X		
Kathy		X		X		
Jimmy	X		Lori repeated two knocks in imitation of the teacher	X		
Paul	X		by the end of the week but was unable to successfully	X		
Debbie		X	repeat four.	X		
Lori		X	Debbie paid little attention to tasks the first two days		X	
			but really improved during the rest of the week			

APPENDIX V

LANGUAGE EVALUATION TOOLS

Bangs, Tina. Birth 3 Scale. Houston, Texas: Houston Speech and Hearing Center.

New test to evaluate language functioning from infancy through age three. May now be available for public distribution. Contact author.

Bzoch, Kenneth R., and League, Richard. The Receptive Expressive Emergent Language Scale (REEL). Gainesville, Florida: The Tree of Life Press.

Assesses both receptive and expressive language skills from birth to thirty-six months. Informant scale.

Crabtree, Margaret. The Houston Test of Language Development. Houston, Texas: The Houston Test Company.

Measure of language development from infancy through age six. The test is divided into two parts: Part I consists of noting characteristics after observation; Part II consists of actual test material presented to the child.

Dunn, Lloyd. Peabody Picture Vocabulary Test. Circle Pines, Minnesota: American Guidance Service.

Measures one word receptive vocabulary ability from ages 2 years 3 months to 18 years 5 months.

Foster, Rochanna, Giddon, Jane J., and Starke, Joel. Assessment of Children's Language Comprehension. Palo Alto: Consulting Psychologists, 1969.

Determines the number of elements which a child can process and provides a description of the nature and the level of the child's difficulty. Good diagnostic tool for determining receptive language as it is related to auditory memory and for distinguishing at what level remediation should begin.

Hannah, Elaine P., and Gardener, Julie O. Preschool Language Screening Test. Northridge, California: Joyce Publications, 1974.

To be used as a screening instrument. Norms are provided for age levels 3 years through 5 years 11 months. Screens the areas of visual perception, motor development, auditory perception, and conceptual development.

Mecham, Jex, Jones. Utah Test of Language Ability. Salt Lake City: Communication Research Association.

Designed to measure receptive and expressive language skills in children 9 months through 16 years.

Mecham, M. J. Verbal Language Development Scale. Minnesota: American Guidance Service, Inc.

Extension of the communication portion of the Vineland Social Maturity Scale. Informant Scale. Tests age 1 month - 16 years.

____________________. Sequenced Inventory of Communication Development. Seattle, Washington: University of Washington Press, 1975.

Tests receptive and expressive language skills for ages 4 months through 4 years. Will be available for distribution in February, 1975.

Zimmerman, Ira Lee, Steiner, Violette B., and Evatt, Robert L. Preschool Language Scale. Columbus, Ohio: Charles C. Merrill Publishing Co.

Scale consists of both an auditory comprehension section and a section to measure verbal ability. Also included is a supplement section to evaluate articulation functioning. Tests age levels 1 year 6 months through 7 years.

APPENDIX VI

MATERIALS:

Earphones
Blocks
Container
Noise Maker
(bell - whistle)

VARIATIONS:

TARGETED BEHAVIOR:

The child drops a block when hearing a sound.

SUCCESS:

PROCEDURE:

Day 1:
Follow Directions under Evaluation Procedure (Steps 2-7).

Day 2:
Prepare the child to accept the earphones:
1.Place them on yourself and allow the child to see you wearing them.
2.Pass a set among the children allowing them to hold them, to feel them, and to try them.
3.Reinforce.
4.When children become accustomed to the earphones allow the children to put them on.

Days 3-4:
1.Give the child a block and place the container in front of him.
2.Help him hold it to his ear.
3.Say "Listen when you hear the sound, drop the block in the can."
4.Ring the bell so the child can see you. As you ring, assist the child in dropping the block in the can.
5.Reinforce. Say "Good Listening! You heard the sound" as you touch the child's ear.
6.Repeat steps 1-5 as you gradually begin to move out of the child's range of vision while ringing the bell. Finally, try to have the child respond independently as you ring the bell behind him.
7.When the child can play the game, vary the noisemaker and the loudness of the sound when you perform Step 4.
8.Carefully place the earphones on the child. (Do not force him to wear them.)

GOALS:

1.Auditory conditioning

EVALUATION PROCEDURE:

BEHAVIOR:
The child will drop a block when hearing a sound.

DIRECTIONS:
1.Place earphones on the child (Omit Step 1 on Day 1-pretest)
2.Give the child a block and help him place it near his ear. Have a container in front of him.
3.Say "Listen, when you hear the sound, drop the block in the can."
4.Stand behind the child and make a sound (i.e. blow a whistle, etc.)
5.The child must independently drop the block.
6.Repeat Steps 2-5.
7.To succeed the child must respond correctly two times.

Days 3-4: (Con't)

9. Repeat procedure in Steps 1-7.

Day 5:
Follow Directions under Evaluation Procedure.
(Steps 1-7)

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HOME LANGUAGE PROGRAM

APPENDIX VII

ALLIED AGENCIES DEVELOPMENTAL TRAINING PROGRAM
Co-sponsored By
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Allied Agencies Center - 320 East Armstrong Ave. - Peoria, Illinois 61603

NAME

			LONG RANGE GOALS: 1. Size concepts big/little 2. Verbal mimic of environmental sounds, speech sounds, and single words				
	Success?				Success?		
Date	Yes	No	Targeted Behavior	Goals	Yes	No	Comments
2-20-27		X	Richard repeats the tapping pattern	matching	X		
			of the mother				
3-13-20		X	Richard mimics the sound the animal makes	verbal mimic	X		Did not mimic "baa"
3-20-26		X	Richard follows the direction "Find the ________" and mimics the label	verbal mimic	X		Enjoyed this activity Had little difficulty finding the correct object, initially

APPENDIX VIII

ACTIVITY CHART

Child's Name ____________________
Home Trainer's
Name ____________________

Week of ____________________

BEHAVIOR:

Richard repeats the tapping pattern

of mother

- = failure
✓ = success

To succeed - must mimic four of six trials correctly.

	W	T	F	M	T
Comments	He can't understand about long and short				
long-short variation		✓	✓	✓	✓
6 knocks	✓	✓	✓	✓	✓
3 knocks	✓		✓	✓	✓
one knock	✓	✓	✓	✓	✓

DAYS

DIRECTIONS:

Day 1

1. Tell Richard, "We're going to play a listening game today. I'm going to knock on the table and I want you to listen and to do just like me. Listen!"
2. Hold Richard's hands still as you knock one time.
3. Release his hands and say "you do it."
4. Reinforce one knock ("Good, Richard - you knocked one time.") If Richard begins to knock again stop him and say "We knock one time, just one! Fade your assistance.

Day 2 & 3

Repeat Day 2 & 3 with longer tapping patterns. (ex. 3 - 6 knocks)

Day 4 & 5

Shake tamborine in various sound patterns, and have Richard mimic the pattern. (Exp. - long - short - long)

1. long shake - short shake
2. short - long

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APPENDIX IX

CORRELATED LANGUAGE PROGRAM

Prelinguistic Inventory for the
Visually Impaired

Materials:

1. Noisemaker
2. Object or food with distinct smell
3. Attractive toy or object
4. Three familiar objects
5. Ball
6. Cup
7. Flashlight
8. Feather
9. Puppet
10. Squeak toy
11. Drum

Code:

◆ Performs behavior consistently
- Behavior not observed
+ Performs behavior inconsistently
N/A Not applicable

CORRELATED LANGUAGE PROGRAM

Prelinguistic Inventory for the Visually Impaired

Name: ______________________________

Birthdate: __________________________

I. Attending

A. Auditory

1. Changes activity in response to voice					
2. Responds to tone of voice. Example, stops to "No!"					
3. Responds to familiar words paired with gestures. Example, his name, bye bye, Daddy, etc.					
4. Reaches for, turns or moves toward source of sound.					
5. Makes sound. Example, pounds on chair, taps foot, etc.					

B. Visual

1. Localizes flashlight in dark room.					
2. Tracks flashlight across midline in dark room.					
3. Responds to facial expressions. Example, child is motivated by an adult's smile.					
4. Tracks a brightly colored puppet.					
5. Reaches for the puppet.					

C. Tactual

1. Changes activity in response to tactual stimulation. (Example, withdraws or positive response.)					
2. Looks at, turns head or reaches for the area of the body being stimulated.					

D. Olfactory

1. Changes activity in response to a smell.					
2. Tracks a smell across the midline.					
3. Reaches for an object that smells.					

E. Following Directions

1. Perseverative activities interfere with attending.					
2. Responds appropriately to simple commands. Example, "Sit down", "come", etc.					

II. Social Communication

1. Cries and/or smiles					
2. Smiles to pleasurable activities.					
3. Tolerates being held.					
4. Vocalizes for pleasure.					
5. Coos					
6. Stretches arms up to be lifted.					
7. In response to unpleasant things or when he wants to retain an objects, pushes adult hand away.					

8. Pushes adult hand toward a desired object.					
9. Vocalizes single sounds.					
10. Laughs appropriately.					
11. Uses voice to get attention.					
12. Babbles					
13. Uses jargon.					
14. When a desired object is in close proximity, leads an adult to it.					

III. Non-Verbal Mimicking

1. Imitates body movement.					
2. Is cooperative while being moved through body movements.					
3. If placed in correct starting position, moves through imitation of adult movement.					
4. Performs motor movement simultaneously with an adult.					
5. Performs motor movement after watching an adult perform it several times.					
6. Watches adult movement and then imitates it.					

IV. Manipulation of Objects

1. Shows no interest in objects.					
2. Holds objects for a few seconds.					
3. Uses all objects in the same way. Example, mouthes, bangs or twirls.					
4. When given an object, explores it. (Circle mode of response: mouth eyes, nose, hands)					
5. Performs action with object. Example, bangs or shakes it.					
6. Uses objects perseveratively.					
7. Uses an object appropriately. Example, rolls ball, hits drum, squeaks toy, etc.					
8. Searches for an object. Example, reaches, turns head to look, etc.					
9. Shows preference for a specific toy or object.					

V. Matching

1. When teacher holds up an object, finds another one that is the same from two objects.					
2. When teacher holds up an object, finds another one that is the same from three objects.					

VI. Verbal Mimicking

1. Imitates coughing.					
2. Imitates environmental sounds.					
3. Echoic responses present.					

4. Mimics speech sound(s).					
5. Mimics syllable(s).					
6. Mimics babble pattern.					
7. Mimics simple word(s).					

VII. Gesturing

1. Gestures					
2. Gestures meaningfully.					
3. Uses gestures to indicate continuance of an action. (Example, the ball stops bounding and the child wants the adult to bounce it, so he moves his hand up and down.)					
4. Uses a gesture to indicate a physical need. (Example: When child sees or feels a cup, he gives the gesture for drink.)					

VIII. Identifying

1. Locates one out of two familiar objects when named.					
2. Locates one out of three familiar objects when named.					

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Knowledge of the sequence of language and speech sound acquisition is necessary in structuring basic activities designed to promote the speech and language development of the 0-3 child. Basic information concerning speech and language development, intervention techniques, and materials that can be utilized in home programming is provided in the following pages.

LANGUAGE DEFINITIONS

ARTICULATION - The production of individual sounds in connected speech.

DISTORTION - An articulation error in which a nonstandard sound is used in place of a standard sound, or it can be stated that the standard sound is distorted. For example, the child may lateralize the production of s.

OMISSIONS - An articulation error in which sounds are omitted but no substitute is used. For example, the child says top for stop.

SUBSTITUTION - An articulation error in which one standard sound is substituted for another standard sound. For example, the child says goggy for doggy.

AUDITORY ACUITY - The physiological ability to receive sounds. The sensation of hearing.

BABBLING - A stage in acquisition of speech during which the child carries on vocal play with random production of different speech sounds.

ECHOLALIA - Imitation of sounds or words others make. No understanding precedes production.

HOLOPHRASES - Single word sentences marked by intonation patterns representative of sentence structures.

JARGON - Vocalization and imitation of adult speech with few intelligible words.

LANGUAGE - A socially agreed upon code used by a considerable community to communicate ideas and feelings. Language is a system which relates sounds to meanings.

EXPRESSIVE LANGUAGE - The communication of ideas and/or feelings to another person through the use of gestures, spoken words, writing, or any combination of these media.

RECEPTIVE LANGUAGE - The receiving of ideas and/or feelings from another person through understanding of gestures, spoken words, writing, or any combination of these media.

LANGUAGE DELAY - Condition in which the child has not acquired the code of his linguistic community or in which the child or adult loses the code after acquiring it.

SENTENCE STRUCTURE - Rules governing the use of vocabulary.

SPEECH - Performance of language.

PATTERN OF NORMAL LANGUAGE DEVELOPMENT

AGE MONTHS	PHYSIOLOGICAL	SOUND ASPECTS	NUMERICAL SIZE OF VOCABULARY	WORD TYPE	GENERAL INTELLIGIBILITY
1	Sucking Swallowing	Crying Small throaty Noises			
2		Grunting, sighing, cooing (plays with vowel sounds)			
3	Smiling	Babbling (self-imitation of vowel-like sounds and syllables)			
4	Laughs aloud				
5		Squeals, growls Socialized vocalization			
6	Locates sources of sound				
7-8	Gestures still more meaningful than sounds	inflection with vocal play to gain attention			
9-12	Waves bye-bye	Echolalia (imitation of sounds others make but he does not understand)			
12		First words	1-3	Nouns	1-2 years words used may be no more than 25% intelligible to unfamiliar listener, jargon near 18 months almost 100% unintelligible, Improvement is noticeable between 21 and 24 months.
18		Jargon (much vocalization and imitation of adult speech with few intelligible words. Usually talks to self, animals or toys)			

PATTERN OF NORMAL LANGUAGE DEVELOPMENT

AGE YEARS	PHYSIOLOGICAL ASPECTS	SOUND ASPECTS	NUMERICAL SIZE OF VOCABULARY	WORD TYPE	SENTENCE LENGTH	GENERAL INTELLIGIBILITY
2		Combines words	100-200	Verbs, nouns		2-3 yrs. Words about 65% intelligible by 2 yrs 70-80% intelligible in context by 3 Many individual sounds faulty but total context generally understood. Some incomprehensibility because of faulty sentence structure
2½		Jargon almost gone, more word combinations and phrases. May be non-fluent.				
3			600-1000	Nouns Verbs, personal pronouns	3-4	
3½					4	
4			1100-1600	More pronouns, some adjectives, adverbs, prepositions, conjunctions		4-5 yrs. Speech is intelligible in context even though some sounds are still faulty
5		Quite fluent	1500-2100		5-6	5-6 yrs. Good
6			2563			
7						

Engel, Rose C. Language Motivating Experiences for Young Children.

DEVELOPMENTAL CHART FOR CONSONANT SOUNDS

By Mildred Templin

Sounds	Age Expected by Position		
	I	M	F
t	3.0	6.0	3.0
n	3.0	3.0	3.0
r	4.0	4.0	3.5
s	4.0	3.5	4.5
l	4.0	4.0	6.0
d	3.0	3.0	4.0
m	3.0	3.0	3.0
k	3.0	3.0	4.0
z	7.0	3.5	7.0
w	3.0	3.0	
ð (th)	6.0	7.0	
h	3.0	3.0	

Sounds	Age Expected By Position		
	I	M	F
b	3.0	3.0	4.0
p	3.0	3.0	3.0
g	3.0	3.0	4.0
f	3.0	3.0	3.0
v	4.0	6.0	6.0
ŋ (ng)		3.0	3.0
j (y)	3.5	3.5	
ʃ (sh)	4.0	4.5	4.0
θ (th)	6.0	6.0	6.0
tʃ (ch)	4.5	4.5	4.5
dʒ (j)	4.0	5.0	7.0
hw (wh)		7.0	7.0
ʒ		7.0	7.0

* * * * * * * * * * * * * *

I - initial position in a word
M - medial position in a word
F - final position in a word

ð - the (th) as in this (voiced)

ŋ - the (ng) as in rang

j - the (y) as in yes

ʃ - the (sh) as in shoe

θ - the (th) as in breath (voiceless)

tʃ - the (ch) as in chair

dʒ - the (j) as in jet

hw - the (wh)as in what

ʒ - as in garage

LANGUAGE INTERVENTION TECHNIQUES

I. Patterning

A. Parallel Talk: Give verbal labels to objects and activities ("I'm opening the book, Bobby is trying to put on his coat, Jenny sneezed.") Self talk on the part of the child is also encouraged.

B. Question-Answer-Question: Provide the structure and wait for the child to respond but don't make him respond. ("What is this? This is a book. What is this?")

C. Answer-Question: Similar to above ("He's crying. What is he doing?")

D. Stress Change: Put emphasis on word child tends to omit in a sentence but do not make him say it after you. ("The boy is happy!")

II. Echoing

A. Expansion: In order to increase the length of the child's utterance, the child's statement is echoed so that a pattern is provided. (Child - "I see a bear." Adult - "Yes, I see a big brown bear.")

B. Correction: In order to improve the quality of the child's utterance, the child's statement is echoed, but correctly. (Child - "Me want cookie." Adult - "Yes, I want a cookie." Child - "Him has two car." Adult - "Yes, he has two cars.")

III. Modeling

A. This is the use of adult structures in response to child's utterance, keeping in mind limits of vocabulary and memory span.

B. This is one of the best techniques and could simply be termed "conversation".

C. Length geared to child's memory span and ability.

Joan Erickson, Assistant Professor, University of Illinois

ALLIED AGENCIES DEVELOPMENTAL TRAINING PROGRAM
Co-sponsored By
Peoria Assn. for Retarded Citizens Inc. & United Cerebral Palsy of Northwestern Ill.
Allied Agencies Center - 320 East Armstrong Ave. - Peoria, Illinois 61603

SPEECH & LANGUAGE

Hints for helping language development in the home:

1. Stoop to his level. It is easier for him to look straight ahead than to look up.
2. Say "Wait" then wait for the child to focus his attention on your face before speaking.
3. Use the words "look" and "listen" with accompanying gesture when appropriate.
4. Hold objects close to your face, if possible, when labeling.
5. Use expression - both facial and vocal. Be enthusiastic!
6. When your child gestures for you to do something for him, such as "Open the box", wait for him to look at you before proceeding. You want him to learn that he is rewarded by "looking".
7. Talk to your child - use simple labels for household items--"Chair "sink", "spoon", etc.
8. When bathing, label body parts--"Head", "arm", "leg", "toes", etc.
9. Use short functional phrases--emphasis on voice inflection. "Good boy", "sit", "over here", etc.
10. When he has learned one phrase, expand on it. "John is a good boy"-- "Sit down", "Bring it over here".
11. Use all opportunities to expose your child to labels--dressing, bathing, eating.
12. Call his attention to household sounds. Make him aware of different kinds of sound--Clock striking, timer buzzing, water running. This will develop his auditory awareness and help him to develop listening skills.
13. Never "drill" a child in labeling or using words. Make any speech activities fun--Play games (Peek-a-boo, etc.). Accept all responses. If your child repeats a word incorrectly, accept it with a smile but be certain you repeat the word so he can hear it correctly.

Items Commonly Found Around the House that Could be Used as Educational Devices

1. Clothespins and loaf pan (Patterning, number concept, fine finger coordination)
2. Pots, pans, and fitted lids (sequencing, matching, What's Missing?, big and little, prepositions, sounds)
3. Sets of measuring spoons or cups (matching, nesting, stacking)
4. Cans - various sizes (Nesting, building, sorting.)
5. Cans - lids removed (rolling, pushing, nesting)
6. Aluminum pie tins (sorting, matching)
7. Plastic bottles (rattles, sizes) and caps (color sorting in TV dinner trays)
8. Metal percolator parts (complex pattern)
9. Empty milk cartons (sorting, stacking) (½ gallon, top cut off for building blocks)
10. Mirror (self-image, self-concept, hide and seek)
11. Oatmeal boxes (prepositions, matching, sorting)
12. Jar lids (various sizes)
13. Muffin tins, egg cartons, small plastic containers (for sorting textures)
14. Beans of all kinds (sorting after 2½ or age when child does not put everything in mouth)
15. Safety pins, nails, and screws of different sizes (matching, sorting texture)
16. Buttons (size, color, sorting, matching textures)
17. Magazine pictures covering different areas of learning (classification, identification, labeling of animals, furniture, fruits)
18. Silverware (sorting, matching, patterning) wooden spoon, metal spoon (difference in sounds, sharp and blunt)
19. All items (one-to-one counting)
20. Use of clothing of all sorts (self-help skills, matching clothing to body parts, color matching)

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21. Use of plastic, unbreakable items such as dishes, glasses, coasters (all concepts)
22. Cookie cutters and outlines (puzzles and lotto games)
23. Large newspaper on wall (outline of child's silhouette with black felt marker) (child fill in features or identify)
24. Foods (shapes, sizes, colors, textures, tastes)
25. Furniture, kitchen equipment, food, boxes, containers (prepositions, colors, textures)
26. Magazine pictures of situations for discussion about attitudes and feelings (how many, where are they going, what happened)
27. Sequence cartoons in newspaper
28. Bars of soap, cereal boxes, cans, jello boxes, pocket and regular size combs (opposite concepts)
29. Pinch clothespin, round clothespin, scissors, knives, plastic fork and spoon, pen-pencil, watch-clock, glass-cup, mitten-glove, ruler-tape measure (similarities-differences in uses)
30. Clothing, dishes (differences such as shirt-long, short, sleeveless, shoes-high, low, laced, buckled, pants-long, short)
31. Puzzles made from magazine pictures (glued on cardboard or backed with clear, plastic, self-adhesive paper, cut out by teacher, can be outlined on another cardboard for easy matching)
32. Many things in the home have something special in common (color, make noise, similar shape, texture, hot-cold, liquid-solid-powder)
33. Clothes for fine motor coordination (buttons, buttonholes, zippers, snaps, laces)
34. Pictures of furniture and appliances (match item to location in home, find geometric shapes in picture and real items: circle-phone dial, doorknob, clock, square-table, windows, rectangle-door, refrigerator)
35. Spools, thread (stringing, sorting, stacking, matching)
36. Hardware items, small pipe fitting (matching, sorting, fine motor coordination)
37. Scraps of material (textures, cutting, pasting, elasticity)
38. Empty boxes - pictures on outside
    a. small (nesting, building, prepositions)

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   b. ones with tops (for hiding items or mailbox game, guessing)

   c. large (prepositions, using child to demonstrate)

   d. large (cutting out ends to form tunnels)

39. Paper bags (drawing, sizes, puppets, costumes)

40. Puzzles of geometric shapes (divided in half, fourth)

41. Toilet tissue and paper towel roller tubes (sizes, shape, rolling, pushing, spying, design painting, matching tube end to circle on paper)

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SPEECH AND LANGUAGE BIBLIOGRAPHY

Adler, Sol. The Non-Verbal Child. Springfield, Illinois: C.C. Thomas, 1964.

Bangs, Tina. Language and Learning Disorders of the Pre-Academic Child. New York: Appleton - Century - Crofts, 1968.

Bar-Adon, Aaron, and Werner, Leopold (eds.). Child Language: A Book of Readings. Englewood Cliffs: Prentice - Hall, 1971.

Bernbaum, Marcia. Early Language Development: An Abstract Bibliography. Urbana, Illinois: University of Illinois Press, Eric Clearinghouse for Early Childhood Education, 1971.

Connor, Leo. Speech for the Deaf Child. Washington, D.C.: Alexander Graham Bell Association for the Deaf, 1971.

Gray, Burl B., and Ryan, Bruce P. A Language Program for the Non-Language Child. Champaign, Illinois: Research Press, 1973.

Greene, Margaret. Learning to Talk: A Parents' Guide for the First Five Years. New York: Harper, 1960.

Greene, Richard. Forgotten Children. San Rafael, California: Leswing, 1972.

Hopper, Robert, and Naremore, Rita C. Children's Speech: A Practical Introduction to Communication. New York: Harper and Rowe, 1973.

King, Rella and Berger, Kenneth. Diagnostic Assessment and Counseling Techniques for Speech Pathologists and Audiologists. Pittsburgh: Stanwix House, 1971.

Lavatelli, C.B. (ed.). Language Training in Early Childhood Education. Urbana, Illinois: University of Illinois Press, Eric Clearinghouse on Early Childhood Education, 1972.

McClean, James C., Yoder, David E., and Schiefelbusch, Richard (eds.). Language Intervention With the Retarded: Developing Strategies. Baltimore: University Park Press, 1972.

Menyuck, Paula. The Development of Speech. Indianapolis: Bobbs-Merrill, 1972.

Schiefelbusch, R.L., Copeland, R.C., and Smith, J.O. (eds.). Language and Mental Retardation. New York: Holt, Rinehart, and Winston, 1967.

Staff of the Developmental Language and Speech Center. Teach Your Child to Talk: A Parent Handbook. Grand Rapids, Michigan: CEBCO - Standard Publishing.

Yardley, Alice. Exploration and Language. New York: Citation Press, 1973.

DO'S AND DON'TS FOR PERSONS WORKING WITH YOUNG CHILDREN IN THE CLASSROOM

Do's

1. Do arrive promptly.
2. Do learn names of children quickly.
3. Do learn where things are kept.
4. Do ask questions freely about children, procedures, and equipment.
5. Do share your own experiences.
6. Do tell stories, play games.
7. Do make the classroom richer for having been there
8. Do work at the child's level when possible; sit or stand with the student.
9. Do give instructions clearly.
10. Do be consistant in rewards.
11. Do handle accidents matter-of-factly and quickly.
12. Do speak positively.
13. Do discuss ideas and suggestions freely.
14. Do question the teacher privately if you disagree with anything you are asked to do.
15. Do respect the privacy of any information regarding students.
16. Do make sure the child experiences some success each time they see you.
17. Do change to an easier task if the child is having trouble accomplishing a task and becomes frustrated.
18. Do enjoy the situation; keep a good sense of humor
19. Do communicate with the teacher regularly.
20. Do leave your work area as you find it.
21. Do guard the child's need for privacy.
22. Do give the child time to think of the answer.
23. Do create a good rapport with the child before you start to help them.

Dont's

1. Don't belittle a child or make comparisons between children.
2. Don't hit a child under any conditions.
3. Don't visit with other adults while on duty.
4. Don't do work for children, such as draw pictures for them, tell them answers.
5. Don't rush the children or nag them.
6. Don't use your feelings as a weapon.
7. Don't criticize the teacher to children or to parents. Tell the teacher your criticism.
8. Don't start projects with children you can't finish.

THE MODULAR SYSTEM AS IMPLEMENTED IN EARLY CHILDHOOD CLASSES

Physical Characteristics

1. It is necessary that the classroom have enclosed areas; generally this is three small areas which are non-distractable so that they are divided by cabinets, so that children working in each of these three areas will not be distracted by children from another area.

2. It is desirable to have a larger area for eating and within that larger area to have an empty space for gross motor activities.

3. The head teacher should be able to stand in one place and view all three stations at one time. This arrangement necessitates that at least two of the partitions be waist high.

4. If possible, it is desirable to facilitate an easy flow of traffic. For example, children completing a task in small group area one should not cross with children in group two.

5. An entirely separate area should be available for diapering. It would be most desirable if there was no overlapping of the sinks that would be used for these tasks.

6. An area is needed for coats and personal belongings of the children such as diapers, toys, boots, and an extra change of clothing. The place for the coats should be by the door.

7. A bulletin board is needed where notes can be posted for such information as medication directions and critical notes that parents might send.

8. A wall will be necessary for displaying the data which is taken on the daily teaching activities done with the children.

9. A place is needed for staff to have a break time. This is a time when the staff member leaves the classroom for a given period of time. This staff room or break area can also be utilized for parent-staff conferences if another separate room is not available.

10. An observation room with a plastic one-way mirror, though not critical, is extremely helpful in this kind of a system.

The progression of changing a classroom from one model to the modular system

1. Set the cabinets in the new structure for the teachers and the students. At this point there would not be a change in the structure of the day, but rather a change of the physical arrangement of the room.

2. It is necessary to ask the teacher to redesign or to organize her day. This would entail the administrative portion of the program working very closely with the teacher.

3. The teacher would establish goals or behavioral objectives. What activities precisely does the teacher want to teach. Establishing these goals helps to define what will be taught throughout each day.

4. It is also necessary to establish the attention span of the children in the classroom. This would determine how long the session should be. The range of teaching sessions vary from ten to thirty minutes. Ten minutes would be an example of what might be used with very small children. Thirty minutes would be an example of what would be used with adolescents and adults.

Targeting each of the general periods in the day as potential learning experiences

For example utilize the quality activity of the learning experience of the child. Do not do the tasks for him. The snack period would be utilized for: A. socialization, B. eating skills, such as drinking from a cup or a straw, eating, cleaning up, setting a table, accounting for your activities, manners, etc. The lunch period would be utilized in the same manner as the snack period, and the departure and arrival times also are to be considered as potential learning experiences. A typical schedule for a day functioning on this type of model will include:

An arrival time, which is approximately thirty minutes
Group Session
Snack
Group teaching activity
Lunch
Nap - not to exceed one hour
Group teaching activity
Departure
Progress assessment

It is the intent of the program to allow the learning process to continue from the moment the child comes into the program until he departs at the end of the day. This is implemented during the arrival time in the following manner. Teacher number 1 is responsible for greeting the children, helping with coats, and checking to see what the child's toileting needs are. It is at this time that the children are checked for dry pants if they are on a toileting program. If a child is wet, he is sent to a table and must stay there until an aid can reach him. The children who are dry are immediately reinforced by being sent to join in activities. Teacher number 3 handles toileting and/or the transporting of children from the bus to the room. This person does not keep data. When most of the children have arrived, the small group activities are started. Data on arrival is taken by teachers number 1 and number 2. They will be taking data, for example, in the areas of toileting, coat removal, and socialization.

What to do in a block of time

The appropriate length of time will be determined by the attention span of the children involved in the groups. The group should be divided into a maximum of six children per group with one teacher for each group. At the end of the teaching period the children move to the next location. The signal for moving would be a bell. One teacher would teach the same activity to three groups, each at a different level. The advantage of this is that each teacher gains expertise in teaching particular skills. The children would be working at their own developmental level. Lesson plans are worked out between the teacner and the aid to increase efficiency of teaching methods.

Staff Patterns

This model can be staffed in two ways. One method involves two aids and one head teacher, and the other utilizes three aids and one head teacher. In the latter the teacher would function as a floater, and hence, would not be participating in direct group teaching. Her functions would include handling potential interruptions, talking with parents if they come to the classroom, taking phone messages, posting accidents, being responsible for children who have seizures, circumventing behavior problems, and periodically taking notes on the teaching procedures in order to have a conference at the end of the day with the aids. It would be encouraged that the teacher would emphasize the positive aspects of the aids' teaching and make recommendations if necessary for improving the teaching of those persons.

Monitoring progress for each child sometimes involves pulling children out of the groups to work on a one to one basis. If you were to choose the first alternative, which includes two teacher aids and one teacher, the procedure would then be that visitors would wait until a change of groups occurs, and therefore, would not be interrupting the teaching sessions. Emergencies could be handled in the following ways. One teacher could cover the emergency and one aid could cover two groups, or two groups could be combined while one teacher takes care of the emergency that occurred.

Subject Matter Areas

A. Academic
B. Social
C. Self-care
D. Language
E. Art activities
F. Structured free play

Structured free play is a time when the teacher would plan and have a specific objective for the child as he enters into the free play situation. For example, the teacher might be getting the child to imitate while she might be stimulating another child to initiate an activity. She might be, also, reinforcing through structured free play activities that have happened in the small group teaching sessions.

How to organize group structure

1. Small groups begin and end with a bell.

2. Teacher's materials should be ready and organized at each teaching station.

3. The teacher should be sitting at the table or on the floor with her materials next to her as the children enter the area.

4. The teacher should immediately greet each child, reinforcing his positive behavior, and the teaching should begin.

5. Short periods of time should be devoted to each student in carrying out the teaching activity. The activity should be presented in an unpredictable manner so that the child is not able to determine when it will be his turn.

6. The children who are readily attending to the activity should be given turns over those children who are not attending. There should be an opportunity for pointed praise. For example, if one child is doing an activity and another is sitting quietly and attending well, the teacher would take a moment to say, "I like the way you are listening."

7. Children who are not attending do not get a turn and are ignored until they do attend.

8. The teacher should concentrate on a single given objective for each small group session. For example, a teacher might have children in her group who would all be working on a self-help skill such as removing a coat. They might be at different levels of that task, but working on the same skill. The teacher should limit the activity to that one specific goal and not cover more than one in a given teaching segment.

9. The session then ends with a bell. A child does not leave a group until he is quiet for 30 seconds. A child who isn't quiet stays at that table with his chair pulled away from the group until he is quiet for 30 seconds even if the next teaching session had begun with another group.

10. At the end of the teaching segment the teacher should record data on each child's performance. A plus is indicated if the child did the task without any help on a given level. The level number and a minus are marked if the skill was not completed. The teacher then puts the data on the wall and picks up the data sheets for the next group.

11. It is imperative that every second or third activity done with the children should be one that is physical.

Guidelines for snack and lunch are very similar

One teacher is assigned to preparation for lunch. Two teachers, teacher number 2 and teacher number 3, continue to teach the small groups. One group will be preparing for eating by doing such things as washing hands, toileting, and checking for dry pants. One teacher will have what is called a holding group in which she continues an activity with a planned structure. When a child leaves the group for lunch he leaves contingent upon his good behavior at that time in the group. They are greeted immediately and given recognition and/or food. It may only be a single bite of bread as he comes to the table. We are at all times interested in avoiding the child's sitting for long periods of time. Lunch can be eaten in large groups or three small groups. During the lunch period one teacher is responsible for four to six children. Each teacher should have one targeted behavior that she is working on with one to two children out of her group, concentrating on each task and taking data. An example of a targeted behavior is the frequency count on the number of times a child throws his plate or the number of times he uses his napkin. If the children are not involved in the clean-up process as part of their program after lunch, one staff person is assigned to clean up. Children should be sent directly into the next activity which might be nap or a structured playtime. The general rule for all activities is that we continue learning during the arrival, departure, snack, and lunch.

Guidelines for departure

Teacher number 1 would supervise the departure activities by helping the children in her group get ready by putting their coats on and continuing to reinforce each child for desired behavior. Teacher number 2 and teacher number 3 continue small group activities until they are needed to aid in departure activities of their group. Then teacher number 3 would remain with a small group while teacher 2 would be supervising the departing activities.

Progress assessment - end of the day

The head teacher does a number of things. She looks over the data of the children on the wall for the day and asks questions about the teaching. She discusses problem behaviors with the teacher aids along with the next day's plan. Termination of progress assessment occurs with a combined effort of the staff to clean up the room. Room clean up should never preceed the progress assessment, as clean up activity is a cue that the day's activities have been completed.

CHILD DEVELOPMENT WORKER

I. Qualifications

1. Minimum 2 years college
2. Basic knowledge of normal child development
3. Experience in working with the preschool child preferably in a day care or classroom setting
4. Insight into dealing with parents of handicapped children

II. Responsibilities

1. Coordination of the prescribed program for the child
2. On-going interpretation and explanation of recommendations made to the family by the various specialists in their respective fields
3. Demonstrating and assisting the parents in the implementation of prescribed program and therapy
4. Arranging for and scheduling monthly program review with the appropriate staffing team members
5. Assisting the family when problems arise by bringing the problem to the attention of specific professional staff members or to the staffing team
6. Being alert to the changing needs of the child and his family
7. Providing follow-up with the family to see that appointments are kept and treatment recommendations followed

ENABLER

I. Qualifications

1. High School diploma
2. Mother or prior experience with young children
3. Congenial personality
4. On the job training under the direction of the Child Development Worker

II. Responsibilities

1. Demonstration and assistance to parents in implementing prescribed programs and therapy under the direct supervision of the Child Development Worker
2. Providing transportation and follow-up with the family to see that appointments are kept

PHYSICAL THERAPIST AND OCCUPATIONAL THERAPIST

I. Qualifications

1. Registered Therapist
2. Training and affiliation in Pediatrics along with physical disabilities affiliation

II. Responsibilities

1. Evaluating motor functions
2. Performing developmental sequencing
    a. Physical Therapist concentrates on gross motor activities; gait training
    b. Occupational Therapist concentrates on upper extremity functional activities; feeding techniques, wheel chair adaptations, perceptual evaluation, and training
3. Consulting with allied staff and classroom teacher
4. Providing parent education

CHILD DEVELOPMENT SUPERVISOR

I. Qualifications

1. Degree or equivalent in Social Work, Child Development, Psychology or related field
2. Experience working with young children

II. Responsibilities

1. Coordinating and executing meaningful education programs which will be taken into the home by the Child Development Worker
2. Supervising Child Development Workers and Enablers
3. Developing comprehensive, realistic education and enrichment programs for parents
4. Organizing and Developmental data collection systems which will reflect services provided and individual client growth

SPEECH AND LANGUAGE THERAPIST

I. Qualifications

1. College degree - Masters
   a. Good background in diagnostic methods and procedures
   b. Strong training emphasis in language development and therapy
   c. Working knowledge in the area of audiclogy
2. Preferably, previous experience in working with young, multiply handicapped children

II. Responsibilities

1. Performing speech and language diagnostic evaluation and re-evaluations
2. Making referral for ancilliay services
   a. Audiology
   b. Otology
   c. Hearing aid evaluations
   d. Palatal functioning evaluation
3. Planning of all homebound language programs for the 0-3 population
4. Providing speech and language therapy where indicated
   a. In the home
   b. Within the agency
   c. In preschools where no therapy services are available
5. When appropriate, referring to outside sources for speech and language therapy when appropriate

NURSE

I. Qualifications

1. Registered Nurse
2. Background in Pediatrics, community health, and/or school nursing

II. Responsibilities

1. Administrating the Denver Developmental Screening Test
2. Taking medical history
3. Setting up appointments for medical clinic
4. Participating in medical clinic
5. Arranging for any medical follow-up and consultative services

Because the area of infant stimulation is relatively new, we feel that proper training is of great importance. The following pages illustrate possible in-service training experiences available through the Peoria Project.

IN-SERVICE TRAINING EXPERIENCES FOR THE PEORIA 0-3 PROGRAM

I. Basic Introduction to the Program
   A. Tour of Agency: This comprehensive tour includes visits to classrooms, the occupational and physical therapy room, and the activity workshop.
   B. Slide tape presentation: This twelve minute presentation offers a general overview of the 0-3 program and replication services.
   C. Flow-of-service evaluation: This concise diagram shows the channels through which a child is evaluated, staffed, and placed in a suitable program.

II. Beginning a new program ny utilizing available services for diagnostic and evaluation
   A. Public schools
   B. Department of Mental Health
   C. Developmental Disabilities
   D. Local pediatricians
   E. General practioners
   F. Nurses

III. Initial intake by head social worker
   A. Starts collecting data on family
   B. Assigns a social worker to the family
   C. If homebound program is indicated, social worker contacts child development worker, and they work together making appointments for the in-depth evaluation of the child.

IV. Diagnostic and Evaluation Services (lasts approximately eight weeks)
   A. Functional Profile (indicates child's developmental age in areas of social, cognitive, linguistic and verbal, gross and fine motor, eating, dressing, and toileting); administered by a child development worker
   B. Denver Developmental (nurse)
   C. Speech evaluation (speech pathologist)
   D. Medical clinic held at St. Francis Hospital on the first, third, and fifth Tuesdays of the month (pediatrician)
      1. Pediatrician may recommend additional diagnostic work (other medical specialties, lab tests, genetic workup and counseling, and clinics)
   E. O.T.-P.T. evaluation (occupational and physical therapists)
   F. Psychological examination for children over 2½ years (psychologist)
   G. After the evaluation is completed, the parents are called in for a conference with the social worker and the child development worker. The results of the evaluation are explained along with a plan or program of ways the parents may help the child's development. The child is then assigned through a staffing to a homebound program (birth - age 2), the day center, or to some other appropriate program in the community.

V. Homebound Program
   A. Child development worker takes individualized activities or lesson plans to the home for a 40 - 60 minute weekly visit.
   B. The plan is introduced to parents, and methods of charting and recording are explained.

C. Children are also brought to the agency for occupational and physical therapy twice weekly for ½ hour sessions.

VI. Day Program

A. Classroom: The three 0-3 classrooms are run on a modular system with specific physical areas for language, gross and fine motor skills, playtime, self-care skills, and sitting and attending. There are 8 - 12 children in an average 0-3 classroom. A head-teacher, two assistant teachers, and two or three foster grandparents are present in each classroom.

B. Speech and language therapy: A speech therapist sees various children in 0-3 classes twice weekly. She also observes in the classes, thus enabling her to devise lessons for the children.

C. Developmental therapy is handled by the occupational and physical therapists who see children individually in the therapy room. They also conduct therapy with the teachers in the classroom once a week.

VII. In-service training experiences

A. Observation
   1. Classrooms
   2. O.T. - P.T. room
   3. Speech therapy room
      a. Speech therapist targeting with child development worker
   4. Medical clinic (first, third, and fifth Tuesdays of each month)
   5. Home visits to learn the procedures and problems in delivering a home program
   6. Staffing (every Tuesday at 1:30)

B. Opportunity for discussion with staff
   1. Replication Coordinator
   2. Program director for day center
   3. Head social worker
   4. Social workers
   5. Director of speech and hearing services
   6. Speech therapists
   7. Nurse
   8. Occupational and physical therapists
   9. Child development workers
   10. Classroom teachers

VIII. Available printed matter

A. Flow of services
B. Evaluation form
C. Functional Profile and guidelines
D. Sample lesson plans
E. Modular classroom
F. Tactile stimulation
G. Vestibular stimulation
H. Feeding the cerebral palsied child
I. OK Adaptive catalog
J. Beckly-Cardy catalog

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SCHEDULE FOR ONE-WEEK IN-SERVICE TRAINING

Monday:	Meet with Replication Coordinator and/or Replication Staff Slide-tape presentation Tour of Agency Classroom Observation	10:00 a.m.
Tuesday:	Medical Clinic (St. Francis Hospital) Staffing	9:00 a.m.
Wednesday:	Classroom observation O.T. - P.T. observation Homebound visit	9:00 a.m.
Thursday:	Classroom observation Observe speech therapy Homebound visit	9:00 a.m.
Friday:	Opportunity for discussion with staff	9:00 a.m.
	Targeting session in O.T. - P.T. room	11:30 a.m.

The Replication Staff is available to work with agencies who are planning and/or developing comprehensive programs for developmentally delayed children, birth to three years of age. Individuals or small groups are invited to see the Peoria 0-3 Project during a one day visit or a two to five day in-service training period. If you are interested, please contact Constance Smiley, Replication Coordinator, or any member of the Replication Staff.

For additional information contact:

Replication Coordinator, 0-3 Project
320 E. Armstrong Avenue
Peoria, Illinois 61603
(Phone number (309) 674-1808 or 672-6340)

If you are interested in visiting the Allied Agencies Developmental Center, please complete the following form and mail it to:

Mrs. Constance Smiley
Replication Coordinator
320 E. Armstrong Avenue
Peoria, Illinois 61603

Name ____________________________________

Agency ____________________________________

Address ____________________________________

Phone ____________________________________

When would you like to visit Allied Agencies? ____________________

(Please give an alternate date) ____________________

Who will be coming from your center? ____________________

What are their positions? ____________________

____

____

What in-service training experiences can we offer? (See VIII - A and B. Please specify those experiences which each of your staff members desires).

____

____

____

____

____

Can we arrange for any overnight accommodations? Yes No

Car rental? Yes No

What is your approximate time of arrival? ____________________

We will confirm your visit as soon as possible by telephone or letter.

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Parental understanding and participation is vital to the success of the child receiving the services of the homebound program. The Child Development Worker's interaction with the family serves as the channel through which understandiing and a positive attitude toward the program on the part of the parents is formed.

THE CHILD DEVELOPMENT WORKER
PARENT, CHILD, AND FAMILY

The Child Development Worker is instrumental in providing aid to parents.

This includes:

1. Scheduling appointments for the child.
2. Providing transportation when needed.
3. Being available for supportive phone consultation.
4. Administering Functional Profile in the home or in the agency.
5. Coordinating evaluation information.
6. Scheduling staffing.
7. Participating in the Parent Conference.

It is felt that parental contact is of utmost importance. After staffing recommendations are made and a program is indicated, the Child Development Worker and the Social Worker assigned to the case meet with the parents to provide information obtained from the evaluation results and staffing recommendations. This is usually a very stressful time for the parents and in many instances, they are totally unprepared for the results. And therefore, it is essential that adequate information and assistance be given to the parents. At this time, an explanation of the home program and the goals that have been projected for their child's future needs to be communicated.

THE CHILD DEVELOPMENT WORKER
PARENT, CHILD, AND FAMILY

Important Qualifications of a Child Development Worker

Acceptance, warmth, understanding, genuineness, objectivity, confidence and knowledge, as well as the ability to listen and talk with people under stress.

A Supportive Role

The Child Development Worker may lack specific professional training in dealing with parents, but her interest, patience, and willingness to listen can be remarkably supportive. An empathic response to the emotional stress of parenthood does not necessarily require extensive training.

Listening

Beck and Meadow pointed out in their study that parents are more likely to listen and integrate painful and unpleasant information from interested and "feeling" individuals. Before providing necessary information the Child Development Worker will need to provide a listening atmosphere for the parent. The most helpful of all supportive roles is that of listening.

Talking

Talking is important. A knowledge about the child's condition and the ability to convey knowledge authoritatively and with confidence but without superiority or authoritarianism is very important.

The Child Development Worker should be able to state clearly and comfortably what she does know about the child's condition and equally comfortable stating what she does not know, but be willing to seek out the needed information and relay it to the parent.

WAYS IN WHICH THE CHILD DEVELOPMENT WORKER CAN BE EFFECTIVE

Productive Relationship:	Establish a productive relationship with the parents by being non-judgemental of parents. Make an effort to understand needs, emotional stress, and feelings of which parents themselves might not be aware.
Lend Support:	Lend support to the parent who feels inadequate about his parenting and or lack of knowledge concerning child development. This support can be given by focussing on some particularly appropriate interaction between the parent and child. The Child Development Worker might say, "You seem to be saying that he enjoys it when you do that and you sound as if you do too" or, "You seem to sense his needs very well."
Consider parental concerns:	Never take parental concerns lightly.
Be honest:	Be honest and forthright. Never paint a "too rosy picture."
Outlining Home Program:	Give parents an adequate description of the program, setting up clear and realistic goals for their child. Discuss objectives and goals with parents. Encourage them to be teachers but to continue to be parents, too. Assure the parent that the program is designed for this child and that it will allow him to succeed no matter how minute the task may seem.
Data Keeping:	Stress the importance of data keeping and demonstrate the activities or lesson to the parent. The parent will need to repeat the demonstration.

PARENT INVOLVEMENT GROUP SERIES

Illustrated in the following pages are three model parent groups devised from groups held at Allied Agencies Developmental Training Center as well as from groups held in conjunction with the Child Development Center, Peoria, Illinois. Each of the three programs are targeted for a specific group of parents: the first program (beginning) is aimed at the parent with no previous parent group involvement; the second (intermediate) being for those parents who have been through the beginning parent group; and the third (advanced) for those who have attended all other prior groups and who now have a strong basis to more indepthly work through their own feelings and expectations in regard to their handicapped child.

Group I Beginners

I. Rationale

A. To provide a means for developing parent knowledge in the specific skill areas of child training and management.

B. To form a supportive climate for families to learn about and share feelings concerning their handicapped child.

C. To provide a basis for community knowledge and support of the center program.

II. Initial Procedures to be Followed with Parents

A. Information provided to the parent during the initial contact should include:

1. That parent education courses will be offered as part of the comprehensive program.

2. That parents are required to attend these courses as they are offered.

3. Assurance that the parents have come to the right place for assistance and that in conjunction with qualified agency personnel they will work to accomplish significant gains in their child's development and training.

B. Parent Meeting should begin as soon as possible after the entry of the child into the program.

1. A notice to parents should be sent to include:

a. The time, place, and purpose of the meeting

b. Arrangements for a baby-sitting service made by the staff

c. A reply card with a section where the parents are to indicate if they cannot attend the reason for the absence.

C. Prior to the initial meeting a family information profile should be compiled on each family to include:

1. The names of persons living in the home and their relation to the child.

2. The ages of the children in the family.

3. The language or languages spoken in the home.

4. The parents' special interests, skills, and hobbies.

5. The personal questions needed to be asked of a family that would bare no relevance to other participating parents but would indicate information necessary for the group leader to conduct a pointed comprehensive group. See Appendix I for sample form.

III. Meeting Organization for Beginning Mothers

A. The Child Development Worker should complete the following prior to the meeting:

1. Extend to mother a personal invitation to attend the meeting.

2. Arrange for the transportation of mothers who have no means to get to the meeting.

3. Arrange to utilize an empty room or a section of an already existing classroom to house the incoming infants.

4. Materials should be gathered that will be necessary for comprehensive infant care.

    a. Pampers

    b. Snacks

    c. Feeding Equipment (i.e. straw bottles, adaptive spoons)

    d. Bibs or cover-ups

    e. Stimulating toys

    f. Adaptive seating (i.e. covered inner tubs, various chair adaptations etc.)

    g. Cots or mats

    h. Diapering essentials

    i. Space for diapering

    j. Extra clothing for the infants

IV. Conducting the Meetings

A. Five consecutive meetings one week apart should be scheduled initially to be held on the same day each week, at the same time, and same location.

B. A social worker or a competent counselor experienced in working with parents should be in charge of the meetings.

1. The group leader beginning with a particular set of mothers should complete the entire course as leader.

2. It is important to remember that:

   a. The initial meeting is the most important in setting the tune for the ensuing relationships to be developed and the progress to be made.

IN OTHER WORDS
THE FIRST MEETING CAN MAKE OR BREAK YOU.

   b. That the parent's feelings and support will have significant bearing on the child's progress.

3. All information concerning the participating mothers should be reviewed before the first meeting; and note should be taken of what subjects to avoid.

4. The group leader should approach mothers participating in the program in a positive manner. Take care to build parent confidence in their own feelings and abilities.

5. It is a good idea to include a few parents from the intermediate or advanced group in your initial meeting.

6. Be sure to have plenty of coffee and refreshments during each meeting. This usually is a help in drawing out the shy mother.

Group II Intermediate

I. Rationale

A. To provide parents with an opportunity to learn alternative approaches to child rearing.

B. To help parents gain a better knowledge in developmental problems and handicapping conditions utilizing community resources.

C. To aid parents in understanding their feelings so that they may develop greater competence in dealing with their children.

II. Program Procedures

A. Summarize briefly the important points covered during the Beginning Parent Group sessions.

B. Pass out to all parents a questionnaire to be filled out during the session regarding what they feel their most important needs are in relation to their handicapped child. Stress that these will serve to structure the format for the upcoming sessions.

1. Include also a checklist for parents to indicate their ideas regarding various speakers and topics that could be covered. See Appendix I.

C. Break for refreshments and socialization time.

PARENTS NEED TO BECOME ACQUAINTED WITH
EACH OTHER TO EFFECTIVELY WORK TOGETHER

D. Compile all information gained from the parent questionnaires on a blackboard to be covered when the group reconvenes.

E. Rank all information gained in order of importance according to parent responses.

1. Determine from the ranking what are the most prevalent concerns and what areas parents wish to cover during the upcoming meetings.

2. Determine how many sessions will comprise this segment and also what time the evening meetings will be held.

3. Evoke from parents a verbal commitment that they will attend all upcoming meetings unless a valid reason can be provided for absence.

F. Send to all parents one week prior to the meeting date a reminder. Included in this correspondence should be:

1. The place, date, and time of the meeting.

2. Topics to be covered.

3. Recommended material to read in preparation for the meeting.

4. The name(s) and profession(s) of any speaker(s) utilize for a particular meeting.

G. If speakers are utilized, the next meeting should be used as both a review and discussion centering around the particular topic covered by the speaker.

III. Possible Subjects and Materials to Consider for Group Education

A. Behavior Modification

B. Alternate approaches to Discipline

C. Language Development

D. Genetic Counseling

E. Motor Activities and Exercises

F. Effective Mothering and Parenting Techniques in Relation to the Handicapped Child.

G. Hyperkinesis.

IV. Professional Speakers that could be Utilized

A. Child Psychologist

B. Pediatric Neurologist

C. Speech and Language Therapist

D. Genetic Counselor

E. Nurse

F. Principal or Program Director from the School.

G. Occupational and/or Physical Therapist

V. See Appendix II for materials that would be utilized for the Intermediate Group.

Group III Advanced

I. Rationale

To provide Parents with a means to:

- A. More indepthly evaluate themselves and their feelings in relation to their handicapped child.
- B. Work through problem areas and times of emotional stress.
- C. Deal effectively with those individuals within the community that come in contact with their handicapped child.

II. See Appendix III and IV for structured parent program materials that could be utilized with advanced groups.

Appendix I

Parent Checklist

I. Rank the following topics according to importance

_____1. Discipline

_____2. Behavior modification

_____3. Feeding Probliems

_____4. Speech and language problems

_____5. Toilet training

_____6. Motor and positioning problems

_____7. Inappropriate behaviorial patterns

II. Indicate by (✓) those professionals you would be most interested in hearing

_____1. Child Psychologist

_____2. Speech and Language

_____3. Geneticist

_____4. Pediatric Neurologist

_____5. Pediatrician

_____6. Nurse

_____7. School Principal or Program Director

_____8. Occupational Therapist

_____9. Physical Therapist

III. Comments

A. Please write your most prevalent need at this moment.

B. Additional Remarks

____
Name

Appendix II

Where Do We Start in Child Management? or

Where am I?
Where do I want to be?
How do I get there?
How do I know I am getting there?

Where am I?

One of the first steps in controlling a child's behavior is to determine if the child's behavior needs changing. In trying to decide if his behavior needs changing, you should:

1. Determine if that behavior is not good (in your opinion) and does it occur with sufficient frequency.
2. If your child continues this behavior will it hurt him physically, emotionally, psychologically, or developmentally? Does this behavior prevent him from achieving a higher developmental area? (Sometimes overlooked by parents and educators.) eg. Dependency hampers development.

Where do I want to be?

After you have decided that you want to change a child's behavior then you must state in writing the behavior that you want to change. This means picking out just one behavior and working on just one behavior. In effect what you are doing by deciding on a behavior that needs changing is setting limits or making a rule. After you pick out a behavior that needs changing, then take a good look at this behavior by recording how often your child does this behavior. Record the number of times on a graph.

How do I get there? - (The easiet way possible)

The simplest course of action that will do the job is the one to select.

The following are some techniques you may want to use in planning an effective child management program. (Next page)

NOTES

Ignoring
Time Out
Quiet Room
Praise
Reinforcement
Cue
Modeling
Consistency
Enforcement
Rules
Limits

The type of techniques you select will depend upon the behavior you want to change and the age of your child. (developmental age)

How Do I Know I am Getting There?

The best way is to look at your graph chart, etc.

V. Individual Session with Parents to help Solve a Discipline Problem

(Discuss problems in group and formulate a plan of action.)

VI. Specific Topics to be Discussed

A. Routines-Bedtime problems
B. Temper tantrums
C. Inappropriate crying
D. Dependent & tearful behavior

Have parents give examples of problems that have been written to help them with the above problems.

VII. Summary - Questions, etc.

Thought for the day-

"I am just as big for me," said he
"As you are big for you."

All of the techniques we have talked about can be used to change behaviors that you feel are not acceptable and, more important; these same techniques may be utilized to establish behaviors that your child does not have, but is ready to learn.

NOTES

Appendix III

Harris, Dr. Thomas. I'm OK--You're OK: A Practical Guide To Transactional Analysis. New York: Harper and Row

The basic premise upon which Transactional Analysis is based is that the individual is responsible for what happens in the future, no matter what has happened in the past. Transactional Analysis, as explained in the book, is both a teaching and a learning device. It distinguishes for the reader three active elements in each person's make up: the Parent, the Adult, and the Child (P-A-C). The goal of Transactional Analysis is to make possible for Parent and Child freedom of choice and creation of new options. Dr. Harris applies the P-A-C System to problems in marriage and child rearing, mental retardation, violence, student revolt, racial prejudices, creativity, adolesence, religion, and international problems. The utilization of Transactional Analysis in groups is discussed extensively.

Becker, Wesley C. Parents Are Teachers: A Child Management Program. Champaign, Illinois: Research Press, 1974.

This book has been designed to help parents learn to be more effective teachers of their children. The program is based on the latest knowledge of teaching methods growing out of the principles of behavior sciences. The principles describe the procedures by which behaviors can be changed in specified ways. Through programmed instruction parents are shown how to systematically use consequences to teach children in positive ways what children need to learn to become more effective people. The Parents Are Teachers program consists of a group leader guide as well as a programmed instructive manual for the parents.

Patterson, Gerald R., and Gullion, M. Elizabeth. Living with Children: New Methods for Parents and Teachers. Champaign, Illinois: Research Press, 1974.

The general approach of this program is one which attempts to trace in detail the manner in which the parent teaches the child and the child teaches the parent. The method is based on a social learning approach--it takes advantage of the fact that people learn most of their behavior patterns from other people. The book is written in programmed instruction form in order for the parent to participate actively as he reads.

James, Muriel, and Jongeward, Dorothy. Born to Win: Transactional Analysis with Gestalt Experiments. Reading, Massachusetts: Addison-Wesley Publishing Company, 1973.

The book is primarily concerned with the authors' interpretation of Transactional Analysis and its application to the daily life of the average person. Gestalt-oriented experiments are used to supplement the transactional analysis theory. According to the author, transactional analysis gives a person a rational method for analyzing and understanding behavior; gestalt therapy gives a person a useful method for discovering and fostering awareness, self-responsibility and genuineness. Case studies are utilized from the authors' own experiences as teachers and counselors to illustrate the principles of the method elaborated on in the text. It is the contention of the author that this book can be used as a text or a study guide for those persons interested in personality theory and interpersonal relationships.

James, Muriel, and Jongeward, Dorothy. Winning with People: Group Exercise in Transactional Analysis. Reading, Massachusetts: Addison-Wesley Publishing Company, 1972

This book is designed as a goup-oriented training tool for rapid learing of Transactional Analysis principles. The book can be used in conjunction with Born to Win as a text or it can be used alone. It features a combination of exercises, fill-in sentences, group activities, and instruction through definitions, examples, and diagrams.

James, Muriel: What Do You Do With Them Now That You've Got Them?: Transactional Analysis for Moms and Dads. Reading, Massachusetts: Addison-Wesley Publishing Co., 1974.

Each chapter begins with a typical family situation and shows parents how they can deal creatively and constructively with feelings and behaviors that arise. An excellent book for divorced parents and step-parents as well as for anyone working with children, especially teachers and family therapists.

Jongeward, Dorothy. Transactional Analysis Overview Cassette Program. Reading, Massachusetts: Addison-Wesley Publishing Co.

A 55-minute audio-tape overview that outlines the dynamics of

Transactional Analysis and provides a framework to utilize this method in several ways. The cassette may be used as the introduction to a series of discussion sessions drawing on the texts, Born to Win or Winning with People.

Appendix IV

Transactional Analysis
by
Kay Griggs

I. Introduction to Transactional Analysis.

A. There are two new approaches to understanding people that give an individual a rational method for analyzing and understanding behavior. They are Gestalt Theraphy and Transactional Analysis.

B. How one compliments the other.

C. Both are tools for change which concentrates on producing "winners" not "losers".

D. How T. A. evolved.

1. T. A., as well as Glasser's Reality Therapy, can be thought of as products of a new breakthrough in psychiatry.

2. T. A. holds with the theory that individuals are responsible for their behavior.

E. T. A. believers know that it is true that one can not "change the past," and they deal with this segment as it insinuates itself into present life experiences.

F. The understanding of our PAC (PARENT, ADULT, CHILD) ego states is important.

G. T. A. has a special language which is used to report "what happened".

1. The language is concerned with the three ego states:

Ⓟ PARENT
Ⓐ ADULT
Ⓒ CHILD

2. T. A. is concerned with four life positions:

I'm not OK - You're OK - denotes inferiority; fear

I'm not-OK - You're not-OK - denotes withdrawal; hopelessness.

I'm not-OK - You're not-OK - denotes anger; attack source of frustration.

I'm OK - You're OK - denotes communication.

3. T. A. followers believe that they cannot help individuals become responsible people until they help them uncover the I'm NOT-OK - YOU'RE NOT-OK position. This position underlies the complicated and destructive GAMES people play.

4. The language helps to build a strong emotional relationship quickly.

H. Eric Berne and Transactional Analysis

II. Assumptions Regarding the Nature of Man.

A. Transactional Analysis is concerned with finding the answer to: Why people DO NOT LIVE AS GOOD AS THEY KNOW HOW ALREADY.

1. It is concerned with the fact that "this inability to understand, to enable us to see the goodness in man" is intensified by problems of nonunderstanding and noncommunication.

2. Transactional Analysis theory is centered around the premise "that man is not totally at the mercy of either his heredity or his environment."

B. Transactional Analysis is concerned with helping people become "Winners" not "Losers".

C. How T. A. influences what the individual does to enhance the fact "that he is basically good". A person who is not aware of how he acts or how he feels is impoverished.

1. T. A. is a tool that can be used to know oneself, to know how one relates to others, and to discover the dramatic course one's life is taking.

2. By becoming aware of one's ego states, one can distinguish between one's various thoughts, feelings, and behavior patterns.

3. One can discover where there is discord and where there is agreement within one's own personality.

4. One can become more aware of the options available to one.

Since T. A. considers "that man is basically good" and therefore is capable of achieving "goodness" and all its ramifications, it provides a frame of reference from which one can evaluate old decisions and behavior and change what one desires to change.

III. The General Over-all Objectives (Goal) of T. A.

A. Berne states the general goal is to establish the most open and authentic communication possible between the affective and intellectual components of the personality.

1. If this happens, one is able to use both his emotions and his intellect, not just one at the expense of the other.

2. Gestalt techniques can accelerate the process *especially* at the *feeling level*.

(Harris states the overall goal is - the restoration of the freedom to change).

B. *The theory behind the goal* is: In T. A. people gain both emotional and intellectual insight, but the *method* focuses on the *latter*. It is a thinking process (often analytical) in which the person frequently concludes, "So that's the way it is!"

1. The METHOD (T.A. LANGUAGE and the PROCESS) FOCUSES ON THE THINKING PROCESS. *THIS CREATES* AN AWARENESS IN THE PERSON.

2. THIS AWARENESS THEN ALLOWS THE INDIVIDUAL TO DEAL WITH HIS FEELINGS ALONE OR WITH SUBSEQUENT HELP.

3. T. A. OPENS UP AVENUES FOR THE PERSON FOR FOLLOW-UP HELP IF IT IS NEEDED.

C. Specific objectives of the T. A. group method. (Originally T. A. was developed as a method of psychotherapy. T. A. *is* preferably used in groups).

1. The group serves as a setting in which people can become:

   a. More aware of themselves
   b. Aware of the structure of their individual personality
   c. How they transact with others
   d. The games they play
   e. The scripts they act out

2. Such awareness enables persons to see themselves more clearly so:

   a. They can change what they want to change.
   b. And strengthen what they want to strengthen.

D. *Specific objectives of a one-to-one T. A. relationship*.

1. It involves the making of a contract between the therapist and client. (It may focus on the alleviation of a symptoms, e.g., frigidity; gaining control, e.g., over excessive drinking). Or it may focus on childhood experiences which *underlie* current specific symptoms and behavior.

2. The contract allows the following specific objectives to be accomplished.

    a. It preserves the self-determination of a client.
    b. It allows the client to know when he's gotten what he came for.

E. Specific objectives which T.A. can accomplish for individuals not in need of indepth counseling or psychotherapy.

1. It provides a thought-provoking perspective of human behavior people can understand and use (the language of PAC-"that is your child talking").

2. It provides a rational approach for understanding a person's behavior (the process of I'm OK - You're OK).

3. It can be used on the job, in the home, classroom, in the neighborhood - where ever people deal with people.

IV. Definition of Counseling or Therapy in Terms of the Theory.

A. The counseling, or therapy, in terms of the theory is concerned with the following:

1. Since in recent years, there has been a great concern about what "psychiatry" accomplishes with its foreverness, high cost, debateable results, and its vague terms, counseling or therapy in terms of the theory is concerned with:

    a. Concentration on methods of finding answers for people who are looking for hard facts in answers to their questions about how the mind operates.

    b. Why people do what they do

    c. How they can stop doing what they do not wish.

2. Since T. A. has given hope to people who have been discouraged by the vagueness of many of the traditional types of psychotherapy, counseling or therapy is concerned with:

    a. Helping those who want to change rather than adjust.

    b. Giving answers to those who want transformation rather than conformation.

B. Therefore, the counseling or therapy allows those involved to:

1. Discover that one is responsible for what happens in the future, no matter what has happened in the past.

2. Allows:

    a. Persons to change
    b. To establish self-control and self-direction
    c. To discover the reality of freedom of choice
    d. To master the precision LANGUAGE (and PROCESS) which makes it possible for the client and therapist to talk about behavior and to know what is meant. (Process-the transactions between the ego-states and, the use of the Four Life-positions).

C. T. A. was originally designed as a group method of treatment. Ideally, the client and therapist have a one to one relationship to make a contract and to explore the LANGUAGE and the PROCESS. Then the client is channeled to a group - A group facilitates and fulfills the great need for supply of treatment (which is one of T. A.'s selling points).

The counseling or therapy in terms of group work centers around the following:

1. It is a teaching and learning device (rather than a confessional or an archcheologic exploration of the psychic cellar).

2. It can involve four times as many clients.

3. Through the use of the LANGUAGE and the PROCESS it gives group members a workable tool.

4. People do not have to be "sick" to benefit from T.A.

D. Therefore, counseling or therapy revolves around the following fact: If the relationship between two people can be made creative and fulfilling, and free from fear than it follows that this can work for two relationships or three or one-hundred.

V. The Therapist's (or Counselor) Role and Responsibility in Changing Behavior and How He Facilitates Behaviorial Changes.

TA is now being used in both private and group treatment.

It is being used in:

1. State hospitals, prisons, youth authority institutions
2. Marital counseling, pastoral counseling
3. Treatment of adolescents and pre-adolescents
4. Family - centered obsterical care
5. And somewhat with the mentally retarded

A. The therapist's over-all role and responsibility
His Role

1. He must be able to assess in his client the need for change that is exhibited.

2. He must know, then, what makes his client want to change.

   a. If they "hurt sufficiently". (They have beat their heads against the same wall for a long time, e.g., alcoholic.)

   b. When there is present a slow type of despair (The "so what" attitude becomes crippling).

   c. They really want to change and are willing to do something about it.

3. Therefore, to facilitate change for the client, the therapist uses words to convey what he knows and uses in his own transactions to the client - so he can know and use the same technique.

B. The therapists overall responsiblity: the Therapist takes on the over-all responsibility to attempt to make every client in treatment an expert in analyzing his own transactions:

1. by letting it be a learning experience
2. by helping the client sort out the data that goes into making his own decisions.

THERE IS NO MAGIC APPLIED BY THE ALL-POWERFUL EXPERT.

C. The therapist's specific role in the INITIAL PHASE of treatment and how he facilitates behavioral changes: Since the treatment of clients in groups is the method of choice by TA followers, the client has to be introduced to TA in the initial (one-to-one) phase by the therapist.

His Role: (The Therapist)

1. To establish a teaching learning method with the aim

of establishing certain specific meanings as a basis for mutual exploration of how PARENT, ADULT, AND CHILD appear in the client's today's transactions. (This is in itself a unique method for it seems to let the client say at the end of this phase, "this gives me hope," "I feel much better").

2. To discuss a "Treatment contract" - The work contract is used as a statement of mutual expectations. (I am here to teach you something, and you are here to learn something).

D. The therapist's specific responsibilites in the initial phase does not make him responsible for a guaranteed cure.

1. IT SIMPLY STATES A PROMISE OF WHAT THE THERAPIST WILL DO AND WHAT THE CLIENT WILL DO.

Because:

a. If either strays from the expectations, it is a simple matter to review the contract.

b. The dialogue involving the contract is facilitated by the NEW LANGUAGE-which opens a way to be specific.

c. The contract allows the client to agree to learn the language of TA and to use it in examing his every day transactions.

2. The therapist, then is responsible to attempt to, in this initial phase, to provide future avenues whereby the client:

a. Can be alleviated of the presenting symptom by being encouraged to partake in this method of treatment to free up his ADULT so he can experience freedom of choice.

b. Be given the opportunity to create new options above and beyond the limiting influence of the past.

E. The therapist's specific role in the GROUP PHASE of treatment and how he facilitates behavorial changes.

There is no magic in the word "group".
A group setting should accomplish the following points listed in order to fulfill the "contract" made in the initial phase by the client and to provide an avenue for him to progress toward his initial goals. The therapist then is responsible to see that the following takes place:

1. Everything that is said in the group needs to be seen and heard by every other group member-every question, answer, and every transaction.

2. The subtle and multiple ways the PARENT reveals itself in transactions needs to be identified and learned.

3. Both the inner and outer threats to the CHILD need to be recognized in a general sense at first - then the unique and specific characteristics of the CHILD in each individual in the group.

4. In addition to the preceding, the therapist must call attention to the mutual confrontation of GAMES-and of "Realities" (where you are).

5. And he must capitilize on the fact that his clients are seen in the natural milieu - involved with other people - instead of being by themselves with a therapist in a separateness that can never be duplicated on the outside.

F. The therapist's specific responsibility in the GROUP PHASE is to help each of the clients to reach his goal as was stated in the INITIAL PHASE "contract". These goals might be: getting well, starting to live, beginning to see and feel what is real, or growing up.

G. Summary of therapist's Role and Responsibilities which are carried out during the INITIAL and GROUP PHASES to facilitate behavorial change.

A. The Role - is that of a teacher, trainer and resource person, with heavy emphasis on involvement.

B. The Responsibilities of the therapist include:

1. Making sure (through the use of the contract) that the goal of the client is clear, concise, and easily stated.

2. Making sure the client understands the language and the process.

3. To allow the client to become expert in analyzing his transactions.

4. To help the client free himself of his symptom and/or reach his stated goal.

C. The Desired Behaviorial changes can be facilitated through:

1. The INITIAL PHASE of treatment (one-to-one relationship).

2. Through GROUP METHODS - with subsequent follow-up if needed.

3. Through practical use of the techniques of the theory (after they have been thoroughly understood and their results evaluated) in day to day life experiences.

VI. How Can Behavorial changes be Identified and Evaluated?

A. TA centers around the premise "that each human being is born with what he needs to win at life". However, they are also born helpless and totally dependent on their environment. (Few of us are total winners or total losers).

To Repeat:
1. Winners successfully make the transition from total helplessness to independence to interdependence.
2. Losers do not. Somewhere along the line they begin to avoid becoming self-responsible.

B. In order to evaluate behaviorial changes the therapist has to identify where the client is on this winner-loser continuum. The therapist must be aware of the characteristics of a loser.

A. Loser

1. Is not aware of how he feels or acts. He is impoverished, and he cannot move toward becoming a whole person.
   - a. He lacks confidence.
   - b. He fluctuates between conflicting inner forces.
2. He is less than whole because he has alienated parts of himself. He may be alleviated from
   - a. His intellect
   - b. His emotions
   - c. His creativeness
   - d. His body feelings
   - e. Or, some of his behavior

C. Behaviorial changes that can be evaluated by the therapist in the client, who has decided to become more of a "winner than a loser" through the use of TA are very evident. The client has allowed himself the luxury of attaining the following insights:

1. Discovers that he can rely more and more on his own capacities for sensing and for making judgements.

   2. Continues to discover and renew himself.

   3. Knows that life for him consists not in getting more - but in being more.

   4. Exhibits the fact he is glad to be alive.

D. To attain the preceeding insights, the client has utilized the following which enables the therapist to evaluate the client's behaviorial change as he proceeds through therapy.

1. He has utilized the tool of TA (the language) to become aware of himself and to know:

   a. Himself

   b. How he relates to others

   c. How he can discover the dramatic course his life is taking.

2. The unit of measure in "the interpersonal relationships" of TA is the transaction; therefore, he has:

   a. Been able to analyze his transactions - his Ⓟ Ⓐ Ⓒ

   b. Gained a more conscious control of how he operates with people and how they operate with him.

   c. Discovers what masks he has been wearing and what games he has been playing.

3. Most important - he has used the tools of TA to form a practical frame of reference from which:

   a. He can evaluate old decisions and behavior.

   b. And can change what he decides is desirable for him to change.

4. He has become familiar with his script messages that are not in tune with his actual potentials, thereby, eliminating the creating of pathology in various degrees. Therefore, he has developed the capacity to determine his own life plan, - to fully integrate and activate his ADULT EGO STATE. (Explanation of Life Scripts is stated below).

   Each client has a psychological script and exists in a culture that has scripts.

A psychological script contains the ongoing program for the client's life drama. It is rooted in his CHILD EGO STATE - messages that he has received from his parents that were either constructive, destructive, or nonproductive in nature.
The client's cultural life script is concerned with the accepted and expected dramatic patterns that occur within a society. They are determined by the spoken and unspoken assumptions believed by the majority of people in a group.

His cultural life script is rooted in his PARENT EGO STATE - messages he has received via his parents and other important individuals concerning cultural aspects.

5. He has found his potential for intimacy (which is a much deeper level of human encounter and the ultimate goal each client should be striving for).

   a. He has realized that intimacy is not concerned just with rituals, past times, games and activities.

   b. He has realized that intimacy is free of games and therefore free of exploitation - that it occurs in those rare moments of human contact that arouse feelings of authentic tenderness, empathy and affection.

   c. He has realized that intimacy is concerned with giving and receiving positive strokes as opposed to negative strokes. (RECOVERING THE CAPACITY FOR INTIMACY IS ONE OF THE MAJOR GOALS OF TA AND IS ONE OF THE MARKS OF AN AUTONOMOUS PERSON - WINNERS RISK genuine INTIMACY - THE ADULT EGO STATE IS IN COMMAND.

References:
The material for this outline presentation was obtained from the following:

Leonard Campos and Paul McCormick, Introduce Yourself to Transactional Analysis - A.T.A. Primer, California: Transactional Pubs, 1972.

Thomas A. Harris, I'm OK - You're OK, New York: Avon Books, 1973.

Muriel James and Dorothy Jongeward, Born to Win, California: Addison-Wesley Publishing Co., 1971.

Do's and Don'ts for Clinicians or Group Leaders Working with Parent Groups.

Do's

1. Do clarify during initial intake parent's responsibility to and expectations for the group.
2. Do compose groups on basis of similarity of needs and concerns so that members may help each other.
3. Do help groups decide on rules for confidentiality.
4. Do support desirable group behavior.
5. Do support each individual within the group.
6. Do encourage sharing of ideas.
7. Do support each member's right to speak.
8. Do involve participants in continuous evaluation of their group experience.
9. Do have a good knowledge of or seek out help from persons who know group dynamics.
10. Do be empathetic, be natural, be yourself.

Don'ts

1. Don't dominate group meetings.
2. Don't be "the expert".
3. Don't let a single member or clique dominate too much group time.
4. Don't sympathize with parents.
5. Don't interrupt or allow interruptions.
6. Don't chastise or be critical of parents.
7. Don't give false hope.
8. Don't reject ideas or thoughts of any group member.
9. Don't use clichés.
10. Don't put persons on the defensive by asking or beginning with "why". "Why did you wait so long?"
11. Don't use unfamiliar terms.